empowersystems™

ONC Certified Comprehensive EHR + Advanced Core HIS

Implementation + Support Manual

empowerInpatient+Ambulatory™

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2011-2012 Drummond certified ONC-ATCB COMPLETE EHR INPATIENT

2011-2012 Drummond certified ONC-ATCB COMPLETE EHR AMBULATORY

This complete EHR is 2011/2012 compliant and has been certified by an ONC-ATCB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments. empowersystems Certified on 9/30/10,empowersystems (Inpatient) #10012010-3716-1 / empowersystems (Ambulatory) #09302010-688-1.

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Chapter 1: Implementation Overview

The Empower Inpatient+Ambulatory™ Implementation Manual will guide your facility through the EmpowerSystems™ (Empower) implementation process. This manual begins with an overview of the implementation process, and is then divided into specific chapters that address the various aspects of the Inpatient/Ambulatory setting.

The Empower Inpatient+Ambulatory™ implementation process is designed to be a seamless and expedient approach to transitioning physicians, nurses, and staff from a handwritten and/or dictation-based environment to the Empower chart. This project will involve various hospital/clinic departments and personnel throughout the stages in the implementation process. A description of the five phases of the Empower Inpatient+Ambulatory™ implementation process is included in Appendix 1B. It is important that the project teams of both Empower and the host hospital maintain clear lines of communication at all times. EmpowerSystems™ commits to a successful implementation, having been through this process many times. This manual addresses both the common processes that all settings share as well as the unique variances in workflow processes, Inpatient/Ambulatory initiatives, and policies and procedures specific to any one institution. In addition to this manual, the Empower Inpatient+Ambulatory™ process requires conveniently scheduled meetings or calls between all parties involved in the implementation.

PHASE I – Project Kickoff & Assessment

Identifying the Inpatient/Ambulatory Resources and Contact Information

In order for Empower to execute the implementation process, it is necessary to identify all key individuals to ensure proper communication. To this end, please complete Appendix 1A and return to your Empower Project Manager within 1 week of the agreement.

Empower Implementation Team Contact Information

The Empower personnel assigned to your facility during the implementation process are available and can be contacted at any time if questions or issues arise. All communication should include your assigned project manager as they are responsible for the coordination and completion of your Empower Inpatient+Ambulatory™ implementation and they have a team of resources available to meet your needs. Your designated Empower Project Manager will also

provide you with a list of contacts should there come a time that you need to contact another individual for a specific issue.

Creating an Implementation Timeline and Project Strategy

The first priority in the implementation process is to create an action plan and timeline. Please familiarize yourself with the sample timeline (Appendix 1B) to ensure that we are coordinated with all steps of the Implementation process. Your Empower Project Manager will work with your identified Project Manager to review this document to both create deadlines and identify resources.

Schedule the First Meeting

Introduce leadership, discuss resources, and detail a preferred time frame for implementation.

Computer Hardware and Support Software Purchasing

This is a time intensive task which can delay the entire implementation if not undertaken early, so we recommend that this step occur on a parallel path with other Empower timelines. If the Inpatient/Ambulatory Departments are unable to purchase these items, the Empower Project Manager may purchase and install these items with payment terms detailed at that time.

Inpatient/Ambulatory IT Responsibilities

Empower software can be connected and configured in about 1 week, once provided with high-speed internet access. After this, the hospital IT staff copies the Empower software (the Empower launcher) onto each client computer. The Empower Inpatient+Ambulatory™ software will reside in a shared folder on the hospital network. Each client computer must be configured to login to the hospital network and to print the chart on a laser printer in the appropriate work station.

Establish a Go Live Date

The Empower Go Live date (a.k.a. First Product Usage or FPU) serves as a rallying point for all parties involved to establish both milestones and deadlines. Once a Go Live date is designated, it should not be changed. Hence it is crucial that all parties adhere to the timeline.

PHASE II – Application Development

Hardware and Software Configuration/Setup

The hospital IT staff is responsible for operating system and support software installation and system connectivity. Once Empower has been provided remote access to the hospital system, the Empower Inpatient+Ambulatory™ system setup will proceed.

Provide Hospital Data

During Phase I, your Project Manager will provide samples of required data to that can be used to customize Empower Inpatient+Ambulatory™ system to your sites needs. Empower will complete this customization and configure the server to prepare for system testing and use.

Interface Development and Go Live Preparation

Interface development and testing should occur parallel to Empower training sessions and implementation. This process can start after Empower has been provided with a high-speed internet connection available to the computer servers, and after the hospital has deployed the client computers with Empower to the training room and the respective clinical departments. For more information on interfaces, see Chapter 13.

PHASE III – Testing, Training, & Technical Readiness

Empower trains all physicians, nurses, and staff members on the system in accord with the hospital workflow, policies, and procedures (See Chapter 4). Empower provides on-site training for SuperUsers over a period of several days during which trainees will be provided with lectures, discussion, and practice on the Empower Inpatient+Ambulatory™ system. Empower physician training is web-based in order to accommodate their potential schedule limitations.

Full details on training parameters can be found in Chapter 3. It is recommended that a computer lab be set up for the training of SuperUsers. After scheduling both the Go Live and the training sessions, these dates cannot be changed without incurring a significant charge by the hospital.

PHASE IV – Go Live

The Empower Go Live will occur on a Tuesday morning after nurse shift change. On the day of Go Live, an Empower team representative will inspect the computer server and work stations, as well as the printers, tracking systems, and all relevant areas. During implementation, workflow and methods of communication will not change, but the transition from paper to computer (Empower) documentation will be immediate. The physician and nurses will enter all clinical documentation, including physician and nurse notes, diagnostic and medical orders, diagnostic results, vital signs, discharge instructions, and prescriptions, on computers at the time of Go Live.

PHASE V – Post Go Live Assessment & Transition

The Empower Go Live team will be onsite in the inpatient/ambulatory setting around the clock until a time that users are deemed comfortable with the software. The Empower team will assist the physicians, nurses, and staff with documentation and navigation of the system. After the Empower team departs, Empower will still be "on-site" at the hospital, but in a remote, virtual environment.

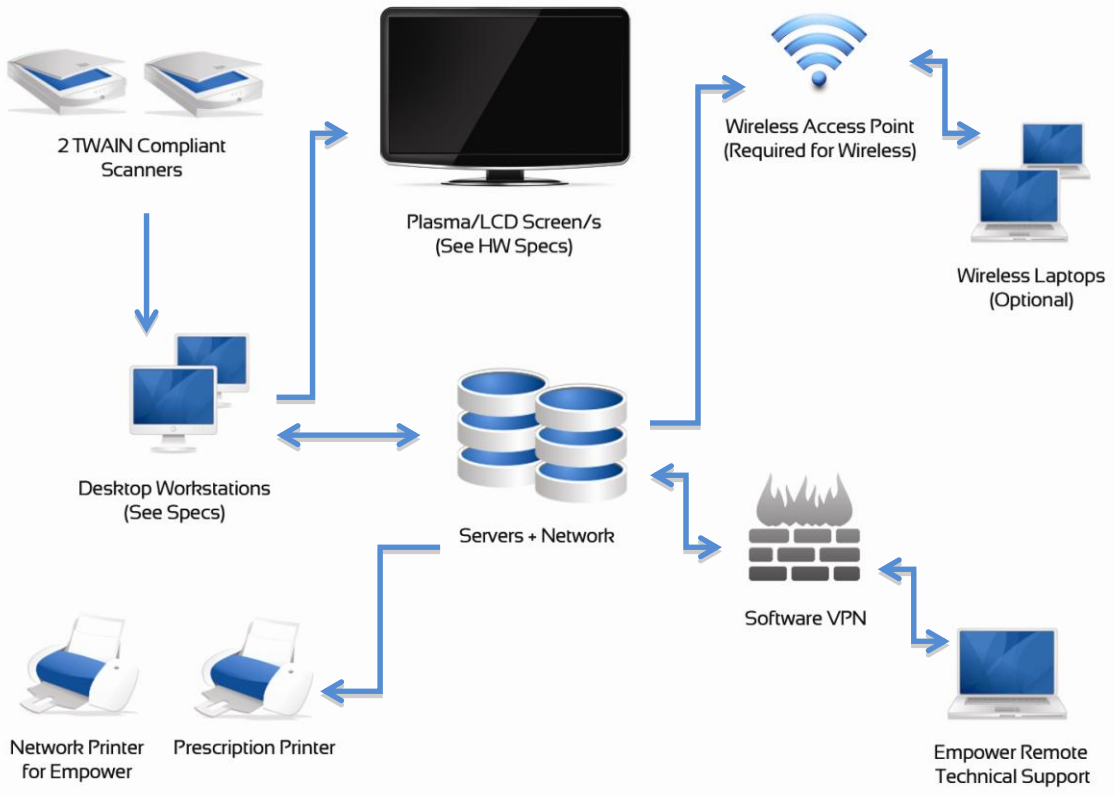
Empower provides technical support both by phone and via remote connectivity in order to respond to questions from front end users. There are many advanced methods to fully maximize the systems' functionality, and Empower wants to be certain that the Inpatient/Ambulatory setting takes full advantage of all of the operational efficiencies (including Meaningful Use) that are built into the system. However, this process takes time and may not all occur during the Go Live week. The Empower team will assign a project/account manager as the long-term resource for questions and needs regarding Empower. Empower senior management also visits its partner hospitals on a regular basis to assist the hospital with not only any issues that may have developed, but also with leveraging many of the new and advanced features of Empower software.

Chapter 2: System Technological Requirements and Specifications

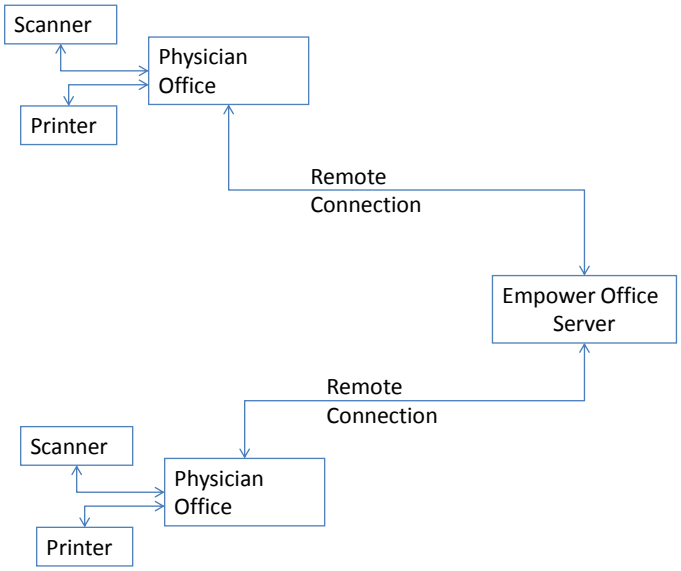
The hospital should provide all of the computer hardware and support software detailed in this chapter. Please forward any questions regarding the following to Empower prior to installation. No software substitutions can be made. Hardware requirements provided below are the minimum for small Inpatient/Ambulatory settings. Mid to large sized facilities generally require a more substantial configuration. Clients should consider increasing the devices performance features if additional software is to be used concurrently with Empower.

Basic Architectural Design

Below is the typical Empower Inpatient™ architecture design and network configuration.



Below is the typical Empower Ambulatory™ architecture design and network configuration.



Network Specifications

The Empower Inpatient+Ambulatory™ software system can function in any network environment, e.g. Star Configuration, Cluster, Citrix, however Empower performs maximally in a Star network configuration. In more complex hospital networks, although there is greater risk that there might be unforeseen software glitches, Empower is committed to resolving any issue that impedes physician and nursing documentation.

Remote Connectivity

The Empower Inpatient+Ambulatory™ software system requires high-speed internet connections to the server and remote software connectivity, either Microsoft Remote Desktop/Terminal Services or PC Anywhere, to each client computer. The Empower Inpatient+Ambulatory™ software system utilizes only software-based, but not hardware-based, VPN products.

Hardware & Support Software Specifications

The hospital will need and should provide the following computer hardware and support software:

SERVER HARDWARE – Live SQL	
Structure	2 Clustered Servers for Redundancy of LIVE System. Attached to SANS with sufficient storage for Scans/PDFs. Size of SANS dependent on amount of scanning and patient Volume. Recommend at least 2TB with expansion for future growth.
Machine CPU / Speed MHx	2 Quad-Core CPU or higher
RAM	64 GB or Higher
Hard Drive Space	200GB+ Local Server RAID (partitioned with 30GB for Op-Sys Partition, remainder in Data Partition)
Optical Drive	DVD-RW Drive
Monitor	17" Flat Screen
Uninterruptible Power Supply	UPS sufficient for both clustered servers in case of brown-out – APC 1500 or higher
Ethernet Card	TCP / IP
*Recommendation for 100+ Beds	2x Intel® Xeon® E7-4870 2.40 GHz, 30M Cache, 6.4 GT/s QPI, Turbo, HT, 10C

SERVER HARDWARE – Test, Application, and Interface Servers (Virtual Machines)	
Machine CPU / Speed MHx	2 Quad-Core CPU
RAM	16 GB or Higher except Terminal Server need 64GB
Hard Drive Space	200GB+ Local Server RAID (partitioned with 30GB for Op-Sys Partition, remainder in Data Partition)

SERVER HARDWARE – Terminal Server (VM)	
Machine CPU / Speed MHx	2 Quad-Core CPU or higher
RAM	64 GB or Higher
Hard Drive Space	200GB+ Local Server RAID (partitioned with 30GB for Op-Sys Partition, remainder in Data Partition)
Optical Drive	DVD-RW Drive

Monitor	17" Flat Screen or other functional equivalents
Uninterruptible Power Supply	UPS dedicated to TS in case of brown-out – APC 1500 or higher
Ethernet Card	TCP / IP

SERVER SUPPORT SOFTWARE – Live SQL	
Requirements	Windows Server 2008 R2 x64 or newer, SQL Server 2008 or newer (with Windows/SQL licenses for needed computers or Terminal Service Licenses) with SQL Studio manager and all client/workstation tools installed. Microsoft Office 2007 (ONLY – not newer) Professional (with Access 2007 full version) installed.

NOTES	
Configuration Benefits	Virtual Machine configuration of supporting servers will incur licensing costs, but yield substantial savings and offer increased flexibility in the long term.
Support	Empower supports virtual servers, however we do not recommend a virtual machine for the LIVE SQL environment. The Test, Application, Interface, PDF generator server(s) could be VMs if the client so desires.

SERVER HARDWARE – Live SQL – Enhanced Capacity Recommended for 100+ Bed Facilities	
Structure	2 Clustered Servers for Redundancy of LIVE System. Attached to SANS with sufficient storage for Scans/PDFs. Size of SANS dependent on amount of scanning and Inpatient+Ambulatory™ Volume. Recommend at least 2TB with expansion for future growth.
Machine CPU / Speed MHx	2x Intel® Xeon® E7-4830 2.13 GHz, 24M, 6.4 GT/s QPI, Turbo, HT, 8C
RAM	128 GB or Higher
Hard Drive Space	200GB+ Local Server RAID (partitioned with 30GB for Op-Sys Partition, remainder in Data Partition)
Optical Drive	DVD-RW Drive
Monitor	17" Flat Screen
Uninterruptible Power Supply	UPS sufficient for both clustered servers in case of brown-out – APC 1500 or higher
Ethernet Card	TCP / IP
*Recommendation for 100+ Beds	2x Intel® Xeon® E7-4870 2.40 GHz, 30M Cache, 6.4 GT/s QPI, Turbo, HT, 10C

SERVER SUPPORT SOFTWARE – Test, Application, Interface Servers	
TEST / APPS Server/ Terminal Server	Windows Server 2008 R2 x64, SQL Server 2008 with SQL Studio manager and all client/workstation tools installed.
PDF Generator	Adobe Acrobat Standard version 7 or newer installed. Microsoft Office 2007 Professional (with Access 2007 full version) installed.
Software for PC Access	Remote desktop/Terminal services enabled for remote access
Virus Software	Anti-Virus Software – hospital standard
Additional Software	Microsoft Office 2007 Professional (for Word and Access)
Additional Licenses	Microsoft SQL Server Enterprise or Standard Edition and Client Access Licenses (CALs) for Windows Server (for workstations requiring access to server)

SERVER SUPPORT SOFTWARE – Terminal Server	
Terminal Server	Windows Server 2008 R2 x64. Microsoft Office 2007 Professional (with Access 2007 full version) installed, and Adobe Acrobat.
Software for PC Access	Remote Desktop/Terminal services enabled for remote access. Remote Desktop licenses are required for every computer used in Inpatient, Ambulatory, and ED units, Hospital Administration, etc.
Virus Software	Anti-Virus Software – hospital standard
Additional Software	Microsoft Office 2007 Professional (for Word and Access)
Additional Licenses	Microsoft SQL Server Enterprise or Standard Edition and Client Access Licenses (CALs) for Windows Server (for workstations requiring access to server)

WORKSTATION HARDWARE	
Machine CPU / Speed MHz	1 Dual-core CPU or higher
RAM	1GB minimum
Hard Drive Space	40GB 7200RPM IDE HD
Monitor	17" or larger flat screen for desktop space efficiency (1024x768 recommended resolution for appropriate Empower viewing)
Mouse / Keyboard	USB optical or laser mouse and keyboard
Ethernet Card	TCP / IP
Scanner (required)*	Cannon DR 2010C / DR 2510C / DR 3010C / Flatbed 101 Add-On
Tablet PC for Signature Capture (required)*	Panasonic CF-H1 / with Cradle CF-VEBH11

WORKSTATION SUPPORT SOFTWARE	
Operating Systems Software	Windows XP SP2+ (with Windows Paint installed so graphic filters are functional on workstation for viewing scanned documents)
Additional Software	Microsoft Access 2007 Runtime (free). *This can be modified based on Terminal Server infrastructure as chosen by client.
Additional Software	Adobe Acrobat Reader version 7 or newer (free)
Virus Software	Anti-Virus Software – hospital standard

The majority are basic recommendations. * Requirements are noted as such. Empower supports a large variety of hardware/software configurations and hospital/office size and volume may dictate changes needed in specifications.

Hardware & Third Party Software

Empower Systems™ does not recommend a hardware vendor or provide hardware to Hospital. Hospital is responsible for the purchase, installation, and maintenance of any hardware required for the product. Empower Systems™ does not recommend any third party software, except for software listed on Hardware & Support Software Specifications (above).

Backup & Anti-Virus Software

Empower Systems™ does not recommend a backup vendor or provide backup software to Hospital. Hospital is responsible for the proper backup of critical dictionaries, files, and point-to-point interfaces. Hospital is responsible for properly restoring backup files in case of a system error or crash. Empower Systems™ does not recommend an antivirus software vendor or provide antivirus software for the product. Hospital is responsible for the purchase, installation, and maintenance of the antivirus software.

***Scanner & Tablet PC Requirements**

For all Inpatient and Ambulatory units Empower Systems™ requires specific scanner models (Cannon DR 2010C / DR 2510C / DR 3010C / Flatbed 101 Add-On) for general use and Tablet PC (Panasonic CF-H1 / with Cradle CF-VEBH11) for signature capture. If a hospital, or unit within the hospital, decides to utilize an alternate Scanner or Tablet PC, there will be $225/hour fee for Empower Systems™ to configure the unapproved device on the hospital network.

Database Backup Options

The hospital is responsible for all software backup and for all recovery of clinical data in the Empower software system. Empower utilizes Microsoft SQL Server software for management and storage of clinical data which allows several options for data storage. Empower's Microsoft SQL Server backup includes:

- Tape cassette
- Local hard drive/directory
- Network hard drive/directory (required)
- RAID hard drives (required)

The frequency of data backup can be adjusted depending on the speed and quality of the hospital computer server hardware. The data back up intervals include:

- 1 hour
- 6 hours
- 12 hours
- 24 hours
- Microsoft SQL software replication: real-time

The hospital can also implement redundant (mirror) computer servers for data backup. Although this increases hardware costs, it essentially guarantees that the Empower servers will never be down due to a hard drive issue.

Software Updates & Patches

Empower deploys the software system updates and patches when the system is approved. The hospital then has 14 days to test the software and accept all Empower updates and software patches. If the hospital refuses the patches or updates then the Empower software live database deployment may be delayed for as long as six to even twelve months. The Project Manager will coordinate with the hospital to ensure that this 14 day period will have the highest probability of success.

Health Insurance Portability and Accountability Act (HIPPA)

Empower is compliant with HIPAA (Health Insurance Portability and Accountability Act) of 1996. Empower requires a user login ID and password for access and, in addition, the passwords can be set to require changing at pre-set time intervals. Empower tracks all users' names and the dates and the times that they access any clinical information. Empower also has an automatic log-off that also can be set to particular time interval. For additional security-related logistics, please refer to Chapter 8.

The hospital must sign a ***Business Associate Agreement*** with Empower in order to be HIPAA compliant. The hospital should provide Empower with this before the Go Live. The clinic may also use the Business Associate Agreement in Appendix 2A. The hospital should provide Ambulatory users with a business agreement also.

Empower Inpatient™ Workstation Setup

Windows XP Workstations vs. Windows 2000 - Windows 2000 requires MDAC 2.8 or newer to be installed, whereas Windows XP has this built-in by default.

Note: The local workstation must have read/write/modify access to a "C:\Empower" folder. The launcher will create and use this as long as the logged-in user has permissions to create/write to that directory.

Please complete the following while logged in as an administrator.

- ❑ Access 2003 or 2007 Runtime, or Access 2003 or 2007 (and no other installed version of Access) which is available on the original full Office 2003 CD in the directory [cdrom]:\FILES\ACCRT\ACCESSRT.MSI.

- ❑ Adobe Acrobat Reader (for printing pre-printed discharge instructions only)
  - Immediately after installation, please launch the Adobe Reader. This will prompt the "license" screen for acceptance. Please click "accept". If the 'Accept' button is not clicked, then in the future the "license" pop-up will not be visible behind the Empower Inpatient+Ambulatory™ program, and hence it will appear as though the system is not responding, when in fact the system is waiting for a response to the pop-up.

- ❑ All client/workstations must have MS Paint installed (or some graphics program that is considered an OLE Server) in order to print signatures.

- ❑ "Empower Launcher" Shortcut
  - Locate the "Empower Launcher" link on the server within the ECDS shared directory.
  - Copy this link/shortcut to the local workstation into the "All Users" desktop. By using this shortcut the most current version of Empower software will be automatically updated.

- ❑ Empower Certificate
  - Locate the file "Empower_Certificate.spc" on the server within the ECDS shared directory.
  - Right-click on Empower_Certificate.spc and choose <INSTALL>
  - Choose <NEXT>
  - Click <Place all certificates in the following store>
  - Choose <Trusted Root Certification Authorities>
  - Click <OK>, <NEXT>, and <FINISH>

- ❑ When the Empower software is run for the first time, it will ask about the security certificate. Please select the check box to install the certificate. It will never ask again for that workstation.

The certificate is a security feature for any software that runs VBA code in order to insure that the code is from a secure source and has not been modified by a virus or other source. If the inpatient users all have unique network logins, then installation of the certificate to all users at once is more challenging. The simplest method to accomplish the installation is to install the certificate (and all other settings described above) for a default user profile. Then copy the entire profile, including all associated files, to the default profile, then delete the user accounts on the workstation. When the users log in again, it will use the default profile's setup certificate.

- ❑ For workstations requiring PDF Browser and/or Custom Reporter, locate the "PDF Browser" link and/or the "Empower Reporter" on the server within the ECDS shared directory, and copy this link/shortcut to the local workstation "All Users" desktop.

- ❑ Install .NET 1.1 or newer. This is not required for workstations that are going to run the Empower Inpatient™ program alone.

- ❑ Empower Inpatient™ references the Windows "default printer" for non-specialized printing. Please be certain that the default printer is defined.

Maintenance of Hardware & Support Software

If any additional computers need to be loaded with the Empower Inpatient+Ambulatory™ software, simply follow the initial setup checklist of the Empower client computers and both hardware and software specifications.

Empower Ambulatory™ Workstation Setup

The hospital will provide a terminal/remote desktop server.

- ❑ Open Remote Desktop Connection and enter the Computer and Username supplied by the hospital. Please enter a password if needed.

- ❑ For ease of access, a shortcut may be saved on the desktop

Chapter 3: Training of Physicians, Nurses, and Support Staff

Empower is designed to be both comprehensive and user-friendly. Most physicians and nurses who are comfortable emailing or surfing the Web require very little training. Agency or temporary staff needs only a brief 15-30 minute in-service. Empower provides on-site training for SuperUsers. These administrative users then train all nursing and ancillary staff. Physician training is provided by Empower via web-based sessions in an effort to accommodate physicians' limited schedule availability. Physicians can join their scheduled session from any location with internet access and a phone connection. The hospital is responsible for scheduling physician training, segmented in 90 minute sessions. While more than one physician can be trained at once, we recommend no more than a 4:1 ratio.

On-site SuperUser training will be scheduled during the implementation process and is coordinated between the project managers. It is recommended that a training environment/computer lab is available with a maximum computer to trainee ration of 1:2. After scheduling the Empower Go Live and training sessions, these dates cannot be altered without the hospital incurring a significant expense. SuperUsers will be identified and instructed on the process of maintaining and creating new user accounts in Empower. These SuperUsers should be able to capture physician signatures via Tablet PC for input to Empower. If the hospital would prefer Empower to load all physician signatures, this can be accommodated at a standard billable rate, provided a completed "Physician Electronic Signature Form" (Appendix 3D) accompanies the request. If physician signatures are not uploaded to the system, charts will print without physician signatures. It is advisable that the hospital provide this form to the Medical Staff Office so that they can include the collection of this information in the physician credentialing process.

Ongoing Training

The hospital must identify a resource (Empower SuperUser) to be responsible for training of new physicians, nurses and ancillary staff after the initial Empower training and Go Live have been completed. This individual will be responsible for all additional clinical staff training. Empower has provided the following skills verification templates for documentation of education records. For User-Specific Manuals, please see Chapters 10-12.

Appendix 3A: Empower MA/RN Skills Verification

Appendix 3B: Empower Registration Skills Verification

Appendix 3C: Empower Provider Skills Verification

Chapter 4: Inpatient + Ambulatory Workflow Perspectives

The inpatient and ambulatory workflow is affected by many internal (registration, medical assistants, etc.) and external (laboratory, radiology, medical records, coding, insurance companies, billing, etc.) factors. There are many different types of workflow:

- Clinical evaluation of the patient (medical assistants, nurses, physicians)
- Clinical documentation (medical assistants, triage, nurses, physicians)
- Clinical communication (medical assistants, triage, nurses, physicians, unit clerks, ancillary staff)
- Registration
- Order entry
- Diagnostic results
- Collating and distributing the chart to medical records
- Collating and distributing the notes to inpatient units and attending physicians
- Collating and distributing the notes to hospital and physician coders and/or billers

Empower takes a phased approach to implementing the Inpatient and Ambulatory systems in order to minimize the impact on all departments. During the Empower Go Live, the greatest impact will be on the physician and nursing documentation. All other aspects of the Inpatient and Ambulatory workflow will remain virtually the same. The workflow process related to collating and distributing the chart will remain unchanged as the current handwritten chart will simply be replaced with a computer-generated chart.

Registration workflow process will be impacted depending on the type of interface design that is articulated in Chapter 13. CPOE will change the unit clerk's workflow and responsibilities as their role changes from entering data/orders into the inpatient ordering system to simply auditing/confirming the order when received electronically in the inpatient information system. The diagnostic results workflow process for laboratory and possibly radiology should continue as usual. Please review the Diagnostic Results section also in Chapter 13.

The collation and distribution of the inpatient chart will initially occur with a printed hard copy. The inpatient chart will also be converted to an image file (PDF), which will be electronically stored on the inpatient network. If the hospital has a document imaging system (Care Center, Chart Script, etc.), then the hospital could work with that vendor to import the Empower PDF so that it can be accessed throughout the Inpatient setting.

The Empower Project Manager assigned to your site will help assess and decide the best way to integrate Empower into your workflow process. Because Empower can function in many different workflow scenarios, it will take some time to see which workflow processes work best for your institution.

The following agenda should be reviewed with your Empower team:

1. **Registration - Quick Reg/Full Reg**
   a. Role of Greeter
   b. Role of Registration
   c. Role of Triage Nurse/Medical Assistant
   d. Full Registration

2. **Paper Chart/Clipboard**
   a. Temporary Triage (Emergency Department)
   b. Other documents, signatures, results

3. **Primary Nursing Documentation**
   a. Use of Empower Response column in Medical Interventions
   b. Use of Empower Clinical Notes; assessments, social information, repeat assessments
   c. Repeat Vital Signs - interface option to consider
   d. Frequent Vital Signs - Print strips, mount and scan OR nurse enters
   e. Scanning

4. **Tech, MA, Unit Secretary**
   a. Vital Signs
   b. Point of Care - EKG, Glucose Check, Urine Dips, and Blood draws
   c. Notifications
   d. Bed Assignments
   e. Nurses Notes - i.e. splint applied (discussion)
   f. Order Entry
   g. Interface Impact on Job Descriptions

5. **Disposition Determined by Physician**
   a. No disposition can be done until the chart is finalized by a physician.
   b. Discharge Instructions driven by physician, nurse can add information.
   c. Physician can print many parts of the chart.

6. Chart Completion by Nurse/MA

a. Consider: Complete entire chart, print entire chart and disposition patient.
b. Consider: For discharged patient, print discharge instructions, return and complete documentation and print entire chart.

7. Bed Management

a. Bed Manager Feature: Who is responsible? Charge Nurse, Floor/ED Nurse, Tech, Secretary?
b. Patient brought to exam room from waiting room: Who is responsible? Tech, MA, Triage RN, Primary RN, other
c. Inpatient/ED room changes: Who is responsible?

Chapter 5: General Clinical Documentation

Physicians, Nurses and Staff Documentation

The transition from paper to computer (Empower) documentation is immediate. Physicians and nurses will enter all clinical documentation on computers at the time of Go Live. The clinical information includes the physician and nursing notes, diagnostic and medical orders, vital signs, discharge instructions, and prescriptions. The initial workflow and communication of information will remain unchanged. A clipboard or binder can still be the center of communication between physicians and nurses until a comfort level is established with documenting in and communicating with computers.

After the nurse completes the triage for a patient, a printed hard copy of the triage note will be placed on the clipboard or binder which is then given to the physician or put in the chart rack. The same will be true for physicians when documenting diagnostic and medical orders, a printed hard copy will be placed on the chart and given to the nurse or unit clerk to execute. When lab results are printed, they will be collated on the ED clipboard or binder for the physician to review. As the CPOE (Computer Physician Order Entry) and diagnostic interfaces go live, this workflow will change (this will be addressed in Chapter 13). As the patient is dispositioned, a printed chart of the entire patient encounter will be sent to medical records or, if the patient is being admitted, with the chart to the floor. After the hospital reaches a certain comfort level with the Empower printed chart, the hospital can reassess the current workflow and start moving towards a completely paperless environment.

Point-of-Care Diagnostic Testing

Empower captures all clinical information in the Inpatient and Ambulatory settings, including point-of-care testing (glucose scan, urine pregnancy, quick hemoglobin, etc.) ordered by physicians and nurses. Nurses and staff should document the point-of-care tests in the Diagnostic/Results or Nursing Notes sections. Test name and result should be documented in the diagnostic form for physician review.

Demographics Printout

Empower has the ability to automatically print demographics Information, which can serve as a notification to the registration clerk, providing them with the patient's name, date of birth, exam room number, and other clinical information.

Discharge Instructions, Clinical Summary, and Physician Follow Up

The staff, using Empower, also can provide patients with information about the follow up physician upon discharge. The staff can document the PCP or specialist's name, office address and office phone number in Empower. The hospital or clinic must provide Empower with contact information for the physicians and specialists in an electronic format. Other physicians and clinics can always be added as needed via the Empower Table Editor or the Discharge Page. Empower also has the capability to automatically fax and/or email the entire note to the referred physician, regardless of whether that physician in an Empower user.

Discharge Instructions (Pre-Written)

When a patient is discharged, Empower can print pre-written diagnosis specific discharge instructions, prescriptions, and a clinical summary of their care in, if needed, a variety of different languages. For those facilities that develop their own custom discharge instructions, Empower can add content as provided in a Microsoft Word document.

In addition to Empower's multilingual Discharge Instruction content, our partnership with ExitCare™ provides clients with access to robust discharge instructions in English and Spanish. Additional languages are available from ExitCare™ for an annual fee based upon hospital volume. ExitCare™ is an industry leader in providing comprehensive, user-friendly, visually engaging content to ED, Inpatient, and Ambulatory environments.

Prescription Writer & e-Prescribing

Empower has a one-click prescription writer, which lists the name, dosage, and route of the medication from one single database in order to expedite documentation of the prescription. The database used is nationally recognized as an industry leader. If a medication is not listed in the prescription writer, simply contact your Project Manager and the new medication can

quickly and easily be added. The prescription writer can also be used to send prescriptions electronically to the pharmacy. The prescriptions are sent via fax numbers that can be added at anytime by the clinic or by your Empower representative.

Bed Control Notification of Admission and Transfers

Empower can also automatically notify Bed Control about all hospital admissions done through the emergency department and all transfers within the hospital.

There are three notifications that can be transmitted to Bed Control:

1. Automatic page providing the following information: patient name, gender, diagnosis, bed assignment, and admitting physician.
2. Electronic notification over the hospital network printing the following information: patient name, gender, diagnosis, bed assignment, and admitting physician.
3. An Empower tracking board can be placed in Bed Control displaying the following information: patient name, gender, diagnosis, bed assignment, and admitting physician.

Order Sets (Guidelines, Protocols, etc.)

Empower has both Diagnostic and Medical Order sets that can be customized to each hospital and physician office. Empower will automatically check-off diagnostic tests on the diagnostic and medical order forms when choosing these order sets from the medical order section. To view the current default diagnostic and medical order sets in Empower, go to the medical order section and choose from Standard Order Set. Modifications or additions to the order sets can be done by a Super User or by an Empower Project Manager.

Admission Orders and Clinical Pathways

Empower allows the physician to enter admission orders or hospital-specific clinical pathways. The Admission Orders functionality is similar to the Standard Order Sets listed above. This is an optional feature. Please communicate with your Empower Project Manager regarding activation/de-activation of this feature. The following clinical pathways currently are deployed to all hospitals. These are fully customizable and can be expanded or deleted.

Congestive Heart Failure	Hyperglycemia	Chest Pain
Pnemonia	Hypoglycemia	Stroke

Drug to Drug Interaction and Allergy Detection

The Smart Technology in Empower employs drug-to-drug interaction and allergy detection for the patient's home medications, medications administered in the office, and the medication given as a prescription. This Smart Technology, however, only works if the nurses and physicians use the correct information and spelling. Our large medicine database also includes hyper-allergenic substances. We encourage users to use this list. When writing orders or prescriptions, physicians have the ability to override both the drug-to-drug interaction and the allergy detection alerts if necessary.

The Empower database, although not all-inclusive, will still identify the vast majority of most drug-to-drug interactions. These drug-to-drug interaction and allergy detection prompts are not meant to replace a physician's clinical judgment. The hospital pharmacy is responsible for maintaining and updating the information in the Empower database, and the pharmacy staff can be provided with access to the Empower table editor for system maintenance.

Scanning Procedure and Outside Information

Empower charts can be imported into the hospital document imaging system (PCI, Care Center, etc.) without having to scan the chart. As the patient is dispositioned from either the ED or Inpatient setting, the chart is converted to a PDF file with a naming convention chosen by the hospital (see Chapter 8). This chart image file can then be imported into the hospital document management system. The Empower chart does not need to be scanned, as it is part of the hospital database and, therefore, the hospital document management system.

Certain clinical information, however, is generated and captured outside of the Empower documentation system (e.g. ambulance run sheet, nursing home transfer sheet, insurance and patient identification card, etc.). Empower recommends this information be scanned at the point of care, and this scanned information will then be included in the PDF chart.

Alternatively, through HL-7 and integration, much of this information can be transferred to a patient's chart electronically.

Abbreviations

Empower has all appropriate Joint Commission-compliant abbreviations. Certain hospitals have created documentation policies that go beyond Joint Commission abbreviations as there may be the potential for confusion between physicians and hospital staff using a handwritten

medical record. Empower believes that some of these policies are outdated, and when applying abbreviations to the printed document we recommend that the hospital review the Empower abbreviations and if the hospital concludes that the abbreviations are acceptable, then the hospital should change the policy on documentation to include the Empower abbreviations for computer-generated charts. Although not all physicians practicing at the hospital are hospital employees, the hospital would still retain control of certain aspects of the program as the servers are housed at the hospital. If the hospital still opts not to utilize Empower abbreviations, then the hospital can designate a resource to use the table editor to change the abbreviations or instruct hospital employees to only use approved abbreviations. Empower employs smart technology to secure information related to risk management, government compliance and coding. Modifying or deleting information in the Empower tables could cause certain features to malfunction, or system errors could arise. A list of the Empower abbreviations is available in Appendix 4A.

Table Editor

Empower is installed with pre-populated lookup tables that contain the common clinical terminology used by physician and nurses. Each field on an Empower form has a lookup table. The internal table editor allows the Super User physicians, nurses and designees to customize these tables to reflect the clinical words and statements most commonly used in that institution or office. The table editor is a very powerful tool as it affords the administrators of the system immediate change capabilities in the database. For this reason, Empower recommends formal discussions and training prior to a user making any changes to the system. The Empower table editor does not provide access to anything that would potentially affect the systems smart technology. Empower recommends populating, but not deleting, tables. If there are any questions, please contact Empower support or your project manager.

Automatic Paging System

Empower has a paging system that will automatically page hospital staff, technicians, bed control, physicians, respiratory therapy, and any others. And as the patient leaves the ED and is transported to the floor, a page can automatically be transmitted to a nurse supervisor or resident physician with all pertinent patient information.

Medication Reconciliation/History

Empower is a Comprehensive ONC Certified Product, and uses an active medication list and true medication reconciliation in accordance with Joint Commission requirements for NPSG 8B. The medication reconciliation report can accurately and completely provide a complete list of the patients' medications for both hospital admissions and hospital discharges, provided the information is properly entered into the Empower Inpatient system. The report contains the home medications as entered into Empower Medication Table and prescription medication also as entered. Active and inactive medications are also listed, as required, as are all medications dispensed in the hospital. On discharge, the home medication table will clearly display all active medications.

Chapter 6: Personalization Policy and Procedures

Although the Empower personalization policy does not allow the deletion of any items from the lookup tables, it does allow unlimited additions, which provides the inpatient and ambulatory setting with maximum benefit while at the same time retaining the user-friendliness, the risk management features, and the single database features of Empower.

During the Data Collection & Application Development phase of the implementation, Empower will populate the tables and generate templates with the information provided by the physicians and staff prior to the Go Live. Once the Empower table editor is available to selected Super User staff and administration, Empower will provide them with instruction to manage the lookup tables. Empower retains the right to limit or expand the availability of certain tables, and your Empower Project Manager is always available to discuss any adjustments to the table editor. Any request for customization that requires changes to the Empower "Source Code" is considered a Supplemental Services project. Examples of such projects may include additions, alterations, or deletions to the following:

Screen/Print Layout

- Labels, fields, or check boxes
- Functionality such as logic, reminders, or required fields driven by individual clinic policies or mandates

If a user request is in alignment with a documented government compliance mandate, then there is no fee for the service. If, however, it is considered a custom or special project, then a written request must be communicated to Empower that includes the scope of the project and any deliverables. Empower will then provide a Statement of Work (SOW) and timeline estimate for testing and delivering the project.

Supplemental Services

Empower is available to complete custom development requests which are supplemental to the standard licensing and maintenance services as stipulated in the client contract. Based on a client request, Empower will assess the scope of work involved and develop a Statement of Work (SOW) including relevant development costs and associated maintenance fees. Your Empower project manager can provide you with a full list of supplemental services offered.

Chapter 7: Coding and Billing

The Empower Inpatient+Ambulatory™ system can code the physician (professional) Level of Service (E & M Evaluation and Management) with accuracy if the clinicians provide the appropriate documentation. In addition, Empower can also assign ICD-9 and CPT codes to diagnoses and procedures if the correct documentation is provided. It has been Empower's experience that certain physicians and physician groups prefer to use certain ICD-9 and CPT codes, whereas other coders at different facilities and or physician groups may prefer other codes. Empower has been designed to customize the ICD-9 and CPT codes to the preference of the individual coders at the facility/hospital or within the physicians group. The Empower table editor allows the facility/hospital and physicians group coders to modify the ICD-9 and CPT codes that are ultimately assigned to the patient's chart. This allows the human coder to become more familiar or comfortable with Empower because they can assign their preferred codes.

In addition, Empower provides a secondary diagnosis. The secondary diagnosis is based on provider input or past medical history. The secondary diagnoses sometimes are not very specific (i.e., cancer, psychiatric, etc.) because the patient is unable to give specific details about a medical problem. Certain secondary diagnoses are more specific (hypertension, asthma, etc.) that are documented in the chart. These secondary diagnoses are listed in Past Medical History, but can be labeled inactive, chronic, or resolved. Many times the physician might treat the patient for chronic medical problem exacerbation (high blood pressure, etc.), but not document hypertension as a primary diagnosis. It can be added in Assessments as a secondary, tertiary, etc. diagnosis. This approach allows the facility coders to capture hypertension as a diagnosis. If the hospital coders do not agree with this approach, then just instruct the physicians not to use additional assessments.

The physician LOS is based on the algorithm (point system) created by CMS (Center for Medicaid and Medicare). The Empower algorithm for coding the physician LOS was created and supervised by a consulting company that is certified by both AHIMA and CCS-P.

Furthermore, it has been Empower experience in working with physician and facility coders around the country that there are gray areas and black and white areas with respect to coding. Coding the gray areas of the chart includes three types of human coders: conservative, middle-of-the-road, and aggressive. Empower takes the position that aggressive coding is ideal, as long as it is supported by clinical documentation. Empower recognizes that certain coders who code the physician and coder/billers might not agree with Empower coding at times.

Empower Inpatient+Ambulatory™ Calculation of RN Level of Service (LOS)

CMS does not currently outline a specific method of assigning nursing levels of service (LOS) as they do with physician LOS. Under the current arrangement, CMS allows individual facilities to implement their own methods of determining LOS, provided all 6 levels are identified (99281, 99282, 99283, 99284, 99285 and 99291). It is expected that all charts are consistently evaluated using the hospital's approved methodology.

Empower has a method built in that provides a "suggested" nursing LOS as designed by our expert coding resources. Empower also includes customizable features to allow individual facilities to adjust the calculation to their approved standards. These customizable features are further detailed below and are preceded by an asterisk (*).

Preliminary RN LOS Calculation

DiagScore (i.e. "Diagnostics", see Figure 1) – this "score" is determined by the total number of diagnostics ordered for the patient. Any diagnostics that are indicated as "cancelled" or "refused" are **EXCLUDED** from this total.

IntScore (i.e. "Medical Orders" see Figure 1) – this "score" comes from how many interventions are ordered for the patient. Any interventions that are "cancelled" or "refused" are **EXCLUDED** from this total.

Example:	DiagScore		IntScore		Total Score
RN LOS **5**	**6 Diagnostic Tests**	**+**	**7 Medical Interventions**	**=**	**13 (Total Score).**

tblluRNLOSCoding			
lngID	**intLevel**	**intLow**	**intHigh**
1	**1**	**0**	**0**
2	**2**	**1**	**1**
3	**3**	**1**	**6**
4	**4**	**5**	**11**
5	**5**	**10**	**16**
6	**6**	**15**	**99**

Total Score = 13

Which falls between **10**&**16**

RN LOS = **5**

*Every hospital has the table above available to them for adjustment of the Low/High ranges to determine the LOS. If you are inclined to alter this table, please use caution and remain cognizant of the systems logic. Please note the overlapping of numbers to be inclusive of the end result (e.g. If you change the 11 to 13 you would need to change the number 10 to 12). If you have questions or concerns regarding the editing of this or any other table in Empower please contact your Empower Project Manager.

Exceptions for RN LOS

Once Empower calculates the preliminary RN LOS, the level of service is still subject to the "exception" list as detailed below.

Intervention Exception

Within the Medical Orders/Intervention table allows for hospital-defined entries, which may not warrant inclusion in the RN LOS calculation. It is for this reason there is an exclusion column to identify interventions the hospital would like to individually omit from this calculation when chosen from the list.

Admission Exception

The RN LOS can be calculated secondarily by the type of unit the patient is admitted to or if IV interventions take place.

tblluRNLOSExceptions		
intLevel	**vchType**	**vchCriteria**
4	A	PYSCH
4	A	DETOX
4	I	
6	A	ICU
6	A	CCU
6	A	Tele
6	A	Telemetry

*This exception table is also customizable for the client. The names of the units can be changed, added or omitted as well as the levels of service indicated for admission to a specific unit.

Currently there are two exceptions that could alter the RN LOS.

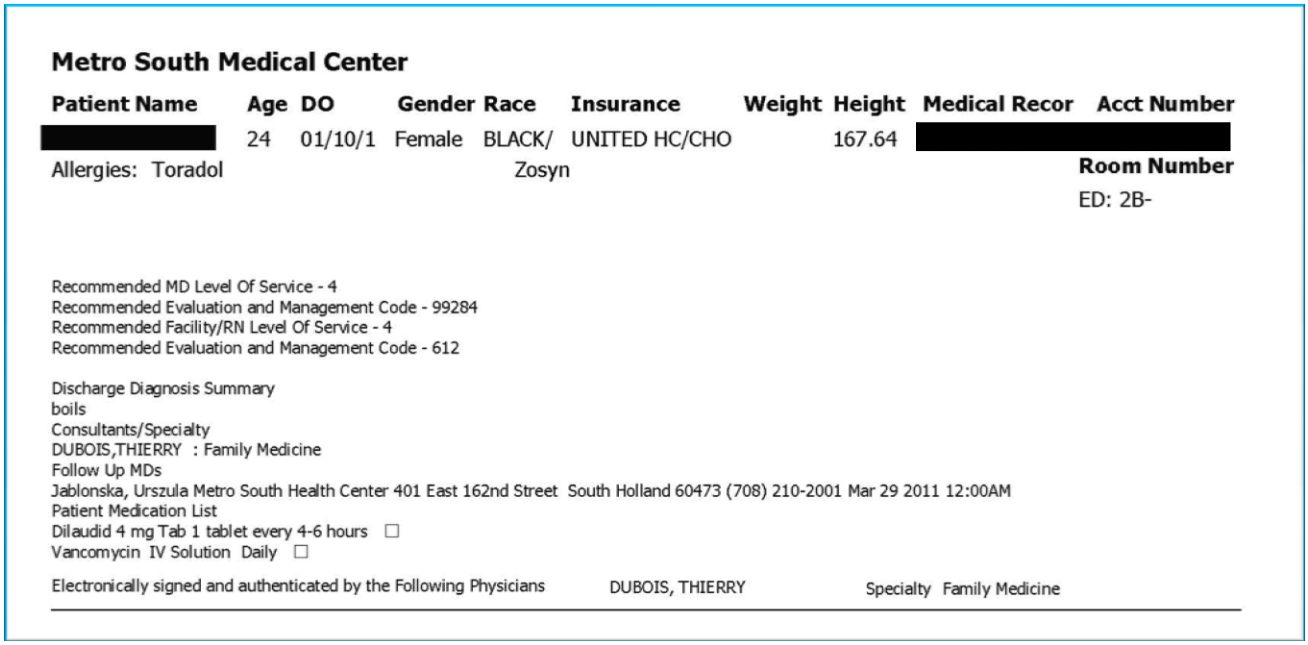
- **vchType A stands for Admit or Transfer to these units.** For example, a patient that is admitted to Psych or Detox would be coded to LOS 4 in this area.

- **vchType I stands for IV interventions.** For example if a patient receives IV medications the chart would be coded to LOS of 4 in this area.

Final Exception and Calculation of RN LOS

Empower takes the **Preliminary RN LOS** and compares it to the **Exceptions for RN LOS** as described above and "suggests" the level that is the greater of the two. Finally, in the case of an admitted or transferred patient to a general medical floor or any unit other than those in the above exception table will receive a LOS=5. This becomes your recommended Empower RN LOS that appears on the EmpowerSystems™ chart.

Figure1



Metro South Medical Center

Patient Name	Age	DO	Gender	Race	Insurance	Weight	Height	Medical Recor	Acct Number
[redacted]	24	01/10/1	Female	BLACK/	UNITED HC/CHO		167.64	[redacted]	

Allergies: Toradol Zosyn

Room Number
ED: 2B-

Recommended MD Level Of Service - 4
Recommended Evaluation and Management Code - 99284
Recommended Facility/RN Level Of Service - 4
Recommended Evaluation and Management Code - 612

Discharge Diagnosis Summary
boils
Consultants/Specialty
DUBOIS,THIERRY : Family Medicine
Follow Up MDs
Jablonska, Urszula Metro South Health Center 401 East 162nd Street South Holland 60473 (708) 210-2001 Mar 29 2011 12:00AM
Patient Medication List
Dilaudid 4 mg Tab 1 tablet every 4-6 hours ☐
Vancomycin IV Solution Daily ☐

Electronically signed and authenticated by the Following Physicians DUBOIS, THIERRY Specialty Family Medicine

Nursing Level of Service

The Nursing Level of Service (LOS) reflects the patient's acuity and the amount of nursing time and skill level that is required to manage the patient in the emergency department.

RN LOS 1 reflects nursing skill level to manage a non-urgent patient. This is represented when no diagnostic or medical orders are executed.

RN LOS 2 reflects nursing skill level to manage a low acuity patient. The nursing intervention and skills are only required for a single diagnostic order, specimen collection, or medical interventions.

RN LOS 3 reflects nursing skill level to manage a semi-urgent patient. The nurse must intervene and execute skills that require multiple Diagnostic Orders, Specimen Collections and/or Medical Interventions.

RN LOS 4 reflects nursing skill level to manage an urgent patient. The nurse must intervene and execute skills that require multiple Diagnostic Orders, Specimen Collections and/or Medical Interventions with IV Insertion or extensive documentation such as Psychiatry or Detox Admissions.

RN LOS 5 reflects nursing skill level to manage an emergent patient. The nurse must intervene and execute skills that require multiple Diagnostic Orders, Specimen Collections and/or Medical Interventions with IV Insertion and extensive documentation for a general hospital admission.

RN LOS 6 reflects nursing skill level to manage a potentially critical or critical patient. The nurse must intervene and execute skills that require multiple Diagnostic Orders, Specimen Collections and/or Medical Interventions with IV Insertion an extensive cardiac monitoring or Intensive Care Unit level of management.

The EmpowerSystems™ RN LOS coding is accurate if the nurse documents all nursing procedures, medications and hospital supplies in the medical intervention section of Empower ED™. The EmpowerSystems™ RN LOS will be down-coded if the Nurse documents any nursing procedures, medications and hospital supplies in the primary nursing note.

- The RN LOS can be adjusted to reflect a hospital's approach to coding (conservative, middle of the road or aggressive). In all approaches to coding, the documentation will support the RN LOS.
- ICD-9 Codes will be applied to all Diagnosis when the physician chooses directly from the EmpowerSystems™ look up tables. If the physician enters a diagnosis by free-texting in the field, then no ICD-9 code will be applied.

Clinical Examples of Nursing LOS with Automated Coding

LOS 1

- 24-year-old male presents for medical clearance after MVA. Patient has no complaints. Patient is triaged and there are no other nursing interventions. Patient is discharged home.

LOS 2

- 55-year-old male has pain on urination. Patient is triaged, urine collected and sent to the laboratory. Patient is discharged home with a prescription and diagnosis of Urinary Tact Infection.

LOS 3

- 17-year-old female presents with ankle pain after a fall. RN Intervention: Urine Collection for Pregnancy Test, X-Ray, Short Leg Post Mold and Crutches. Patient is discharged home with a prescription for pain medication with a diagnosis of Ankle Avulsion Fracture.

LOS 4

- 4-month-old boy presents with fever of 104°. RN Intervention: IV Insertion, Blood Collection, Urine Collection and Anti -Pyretic PO. Patient is discharged home with a prescription for fever with a diagnosis of Viral Syndrome.

LOS 5

- 55-year-old male Diabetic presents with fever and leg redness. RN IV Insertion, Blood Collection, Urine Collection. Antibiotics infused and patient is admitted to general medical floor of the hospital with a diagnosis of Cellulitis.

LOS 6

- 78-year-old female with Coronary Artery Disease presents with Chest Pain. RN Intervention: IV Insertion, Blood Collection, ECG, Chest X-Ray, Sublingual Nitroglycerin, Nitroglycerin Drip, Aspirin and Heparin Infusion. Patient admitted to the ICU with a diagnosis of Unstable Angina.

Coding Grid of Common ED Diagnoses

RN Work Load Diagnosis	No Intervention	Single Intervention	Multiple Interventions	IV Insertion IV Medicine	Admission/ Transfer General Medical Floor	Admission/ Transfer Tele, CCU.ICU
High BP-Transient	RN LOS 1	x	x	x	x	x
Medical Clearance	RN LOS 1	x	x	x	x	x
Otitis Media w/o fever	RN LOS 1	x	x	x	x	x
Tactile Fever	RN LOS 1	x	x	x	x	x
Wound Check	RN LOS 1	x	x	x	x	x
Contusion	x	RN LOS 2	x	x	x	x
Otitis Media with fever	x	RN LOS 2	x	x	x	x
Pharyngitis	x	RN LOS 2	x	x	x	x
Strain	x	RN LOS 2	x	x	x	x
Toothache	x	RN LOS 2	x	x	x	x
URI	x	RN LOS 2	x	x	x	x
UTI	x	RN LOS 2	x	x	x	x
Asthma Mild	x	x	RN LOS 3	x	x	x
Conjunctivitis	x	x	RN LOS 3	x	x	x
DUB	x	x	RN LOS 3	x	x	x
Laceration	x	x	RN LOS 3	x	x	x
Migrane	x	x	RN LOS 3	x	x	x
VagBleeding w/o Pregnancy	x	x	RN LOS 3	x	x	x
Abdominal Pain	x	x	x	RN LOS 4	x	x
Asthma Mod	x	x	x	RN LOS 4	x	x
Asthma Mod/Severe	x	x	x	RN LOS 4	x	x
Dehydration	x	x	x	RN LOS 4	x	x
Kidney Stone	x	x	x	RN LOS 4	x	x
VagBleeding w/ Pregnancy	x	x	x	RN LOS 4	x	x
CVA	x	x	x	x	RN LOS 5	x
Hip Fracture	x	x	x	x	RN LOS 5	x
Hyperglycemia	x	x	x	x	RN LOS 5	x
Incomplete AB	x	x	x	x	RN LOS 5	x
Pneumonia	x	x	x	x	RN LOS 5	x
PyleoNephritis	x	x	x	x	RN LOS 5	x
Threatened AB	x	x	x	x	RN LOS 5	x
Angina	x	x	x	x	x	RN LOS 6
Chest Pain	x	x	x	x	x	RN LOS 6
CHF	x	x	x	x	x	RN LOS 6
Intracranial Bleed	x	x	x	x	x	RN LOS 6
Sepsis	x	x	x	x	x	RN LOS 6
Syncope	x	x	x	x	x	RN LOS 6

Physician LOS Calculation

Levels of service are determined based on three factors:

- History
  - HPI-History of present illness
  - PFSH-Past medical, family and social history
  - ROS-Review of systems
- Examination
- Medical Decision-Making
  - Number of diagnosis or management options
  - Amount or complexity of data to review
  - Risk of complication or death if condition goes untreated

Empower draws this information from structured fields within the system, and then determines a suggested level of service. Levels of service should be audited or reviewed by a certified medical professional. The method Empower uses in determining medical decision-making is based on CPT guidelines and the "Marshfield Rules" as suggested by CMS.

Empower breaks down the medical decision-making in the following manner:

Number of Dx's and Management options:

No diagnostic tests	**= Level 3**
One Diagnostic test	**= Level 4**
Two or more diagnostic tests	**= Level 5**

Amount and/or Complexity of Data Reviewed:

Lab tests (1pt)	**<2 pts=Level 1**
Radiology (1 pt)	**2 pts=Level 2**
EKG/PO2/PEFR/Cont PO2/Cardiac Monitor (1 pt)	**3 pts=Level 3**
PCP Consult (2 pts)	**3 pts=Level 4**
Review of old medical records/old EKG (1 pt)	**4 pts=Level 5**
Additional hx from PD/FD/Family/NH/Friend (2pts)	

Risk of Complications, Morbidity and/or Mortality:

Diagnostic tests		**x**		**x**	**x**	**x**
Medical intervention			**x**	**x**	**x**	**x**
Admission or transfer to Gen Med Floor					**x**	
Admission or transfer to Tele, ICU or Surgery						**x**
	I	**II**	**II**	**III**	**IV**	**V**

Empower then uses this formula to determine the preliminary "suggested" physician LOS:

	Number of Dx and Management mgmt options
+	**Amount and/or Complexity of data reviewed**
+	**Risk of Complications, Morbidity and/or Mortality**
=	**Total divided by 3 (i.e. averaged) = Preliminary "suggested" Level of service**

For example:

Number of dx and mgmt options	**=**	**Level 3**
Amount and/or complexity of data reviewed	**=**	**Level 4**
Risk of Complications, Morbidity and/or Mortality	**=**	**Level 2**
3+4+2=9 divided by 3 (averaged)	**=**	**3 or preliminary "suggested" level 3**

In addition to this formula Empower compares the preliminary "suggested" level of service to the exception list seen below and determines a secondary "suggested" level of service. The higher of these two levels is the one that is used for the final "suggested" level of service provided HPI (history of present illness), ROS (Review of Systems), PFSH (Past medical, Family and Social history) and Examination are documented appropriately to support the "suggested" level per the 1995 CMS guidelines.

Empower Exceptions

Level 5 Exceptions

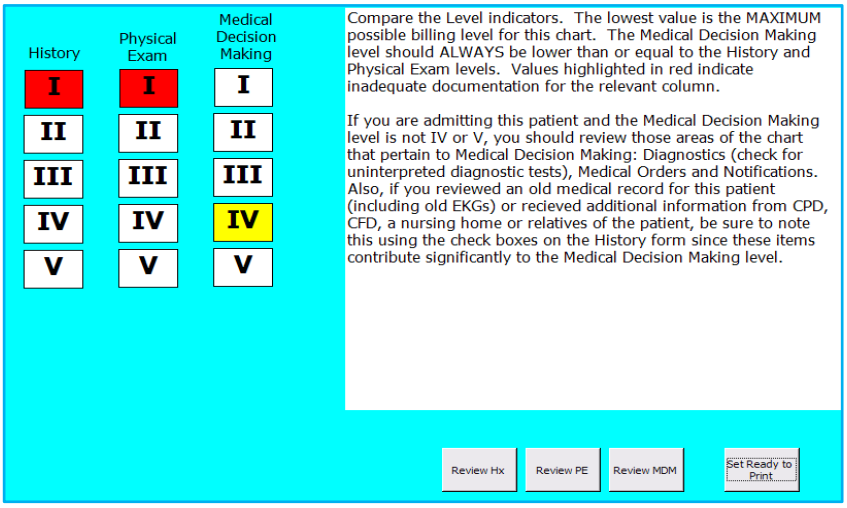
Admission for Psych if documented Suicidal, Homicidal, or unable to care for self
Blood/Urine + EKG + Radiology Test

Level 4 Exceptions

2 or more Diagnostic Panels e.g. CBC, Chem7, Liver Profile
1 or more CAT scans, MRI, Ultrasound or Nuclear Medicine diagnostics ordered
1 or more IV, IVP, or IVPB ordered
3 or more Standard Tests
2 or more Albuterol Txordered
1 hour or longer Albuterol Txordered
Chem20, Trauma panel, MI Panel, CVA Panel, CMP or Comprehensive Metabolic Panel, ICU/CCU Panel, Chest Pain Panel or Abdominal Pain Panel ordered

Level 3 Exceptions

1 or more IM, PO, SQ orders
1 or more Prescriptions given at discharge
Discharge Instructions include pre-written instruction for Head Injury
Admission for Detox
1 Diagnostic Panel e.g. CBC, Chem 7, Liver Profile
Crisis Evaluation. Psychiatric Evaluation


History
Physical Exam
Medical Decision Making
I
II
III
IV
V
Compare the Level indicators. The lowest value is the MAXIMUM possible billing level for this chart. The Medical Decision Making level should ALWAYS be lower than or equal to the History and Physical Exam levels. Values highlighted in red indicate inadequate documentation for the relevant column.
If you are admitting this patient and the Medical Decision Making level is not IV or V, you should review those areas of the chart that pertain to Medical Decision Making: Diagnostics (check for uninterpreted diagnostic tests), Medical Orders and Notifications. Also, if you reviewed an old medical record for this patient (including old EKGs) or recieved additional information from CPD, CFD, a nursing home or relatives of the patient, be sure to note this using the check boxes on the History form since these items contribute significantly to the Medical Decision Making level.
Review Hx
Review PE
Review MDM
Set Ready to Print

The example above identifies this chart could have been coded a Level IV based on Medical Decision Making. However, it would be down coded to a Level I if the physician does not review and provide additional documentation of History and Physical Exam to support the MDM.

Every physician sees this screen when they 'Set Ready to Print.' It offers the provider the opportunity to complete any documentation that may have been overlooked initially.

Chapter 8: Medical Records and Health Information Security

According to hospital policy and procedures, the hospital Medical Records department is responsible for the security and storage and of the medical record. Although Empower is not responsible for this security, it still provides a moderate to high level of HIPAA compliant security. For additional security, the Empower chart can be locked for any period of time that the hospital may require.

Although Empower is not responsible for medical record storage, it can still provide a very accurate back up copy, and can also provide the hospital with a hard copy of the chart should Medical Records prefer the traditional paper chart. Additionally, Empower will provide an electronic PDF image of the chart for storage in an electronic format which can also be uploaded into a hospital document imaging and management system. Each chart is an individual file that is labeled with the patient's name and account number so that the image file can be imported directly into the patient's electronic health record. Additionally, as the chart is an image file, it does not need to be scanned into the hospital document imaging and management system, instead it is automatically imported into the Empower EHR.

Image File (Empower PDF Chart)

As it is much easier to "hack" into a database and alter information than it is to modify a paper document or image file, Empower believes that the security of the clinical information is better preserved when the information is stored as a hard copy document or image file as opposed to discrete data stored in a database.

Because clinical information is dynamic, Empower allows clinicians to update or modify certain clinical information until the chart is locked and the patient has been dispositioned. In order for Empower smart technology to work correctly, the patient record must contain current and accurate information.

At this time, Empower does not track edits or updated information unless it is documented in Additional Clinical Information and/or Exam Notes section of the physicians chart, or in the Clinical Notes section of nursing chart. If the hospital wants to be aware of all edited or updated information, the staff should document all new information in the Repeat Exam or Nursing Notes sections. Empower can also lock the entire chart after a certain period of time has passed since the patient has been dispositioned from the ED and the chart has been printed. It can also configure different lockout times for each Inpatient, ED, and Ambulatory

module. If this feature is desired, simply notify the Empower Project Manager and Empower will be configured for this task.

PDF Storage/Document Management System

After a patient is dispositioned, the chart is converted into an Adobe PDF file and sent to a network location dictated by the hospital. The location is configurable, and it can be anywhere on the hospital's network where the Empower server has write access to the directory. The PDF file name can be formatted in 1 of 6 different ways:

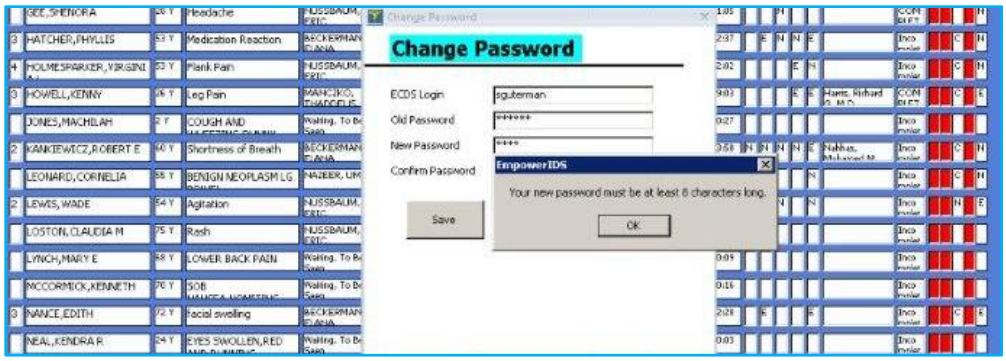
Naming Convention	Example
<account number>.pdf	123456789.pdf
<patient id>.pdf – Empower unique ID	JD-1-18-2008-15:6.pdf
<lastname><firstname>.pdf	doejohn.pdf
<account number><patient name>.pdf	123456789doejohn.pdf
<lastname><firstname><accountnumber>.pdf	Doejohn123456789.pdf
<medical record>_<account number>.pdf *(note the underscore)*	MR9999_123456789.pdf

The format must apply to all PDFs and cannot be changed. There cannot be different formats for different patients. However, additional copies can be made using a different format. For example, the medical records department may require that a file is named one way, while the billing department may require it named another. In these cases, two sets of the patients charts are created, and the copies can be directed anywhere that the Empower server has write access to the directory and the format options are the same options listed above. The local network administrator can determine the file location. Once exported to the network, the PDF chart is available for the hospital to import into any hospital document management system.

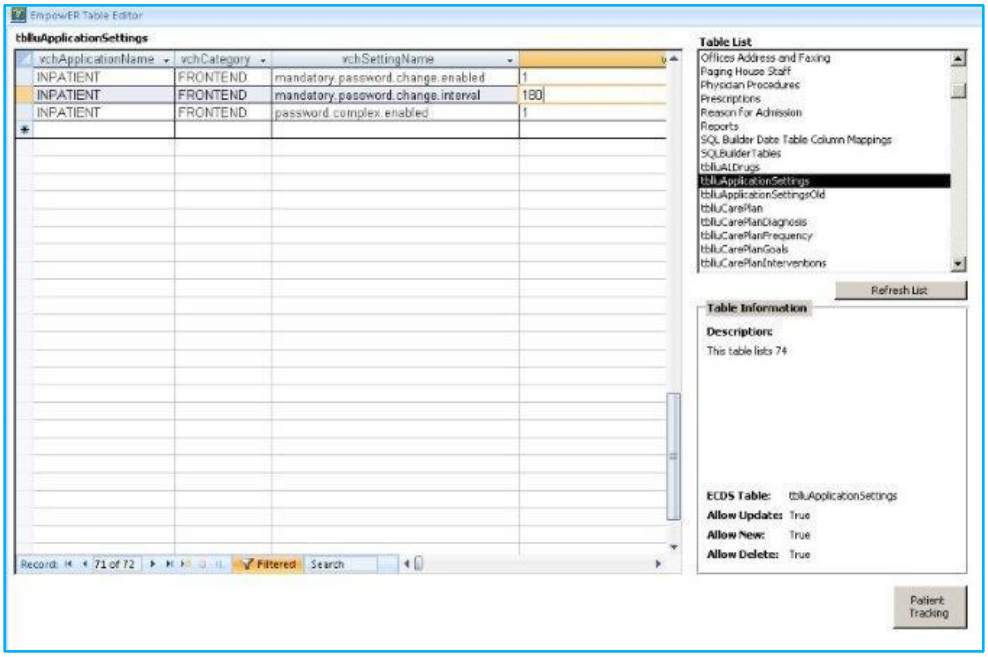
Security for Personal Health Information

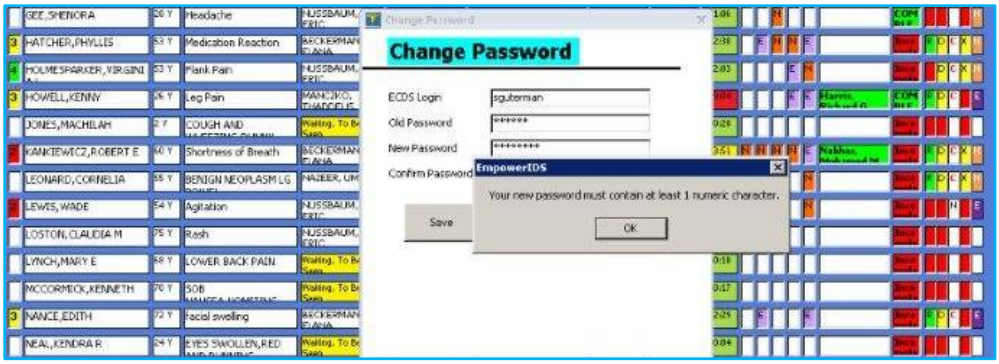
Per ONC-ATCB EHR Certification requirements, Empower provides client administrators with a variety of tools to configure security settings per their institution's security policy for personal health information. Please refer to the following examples:

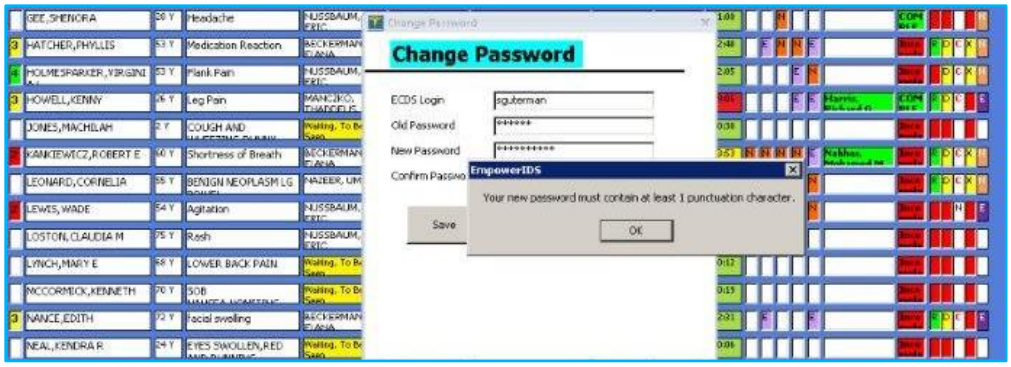
Password Length: Can require users to select an 8 character minimum requirement.



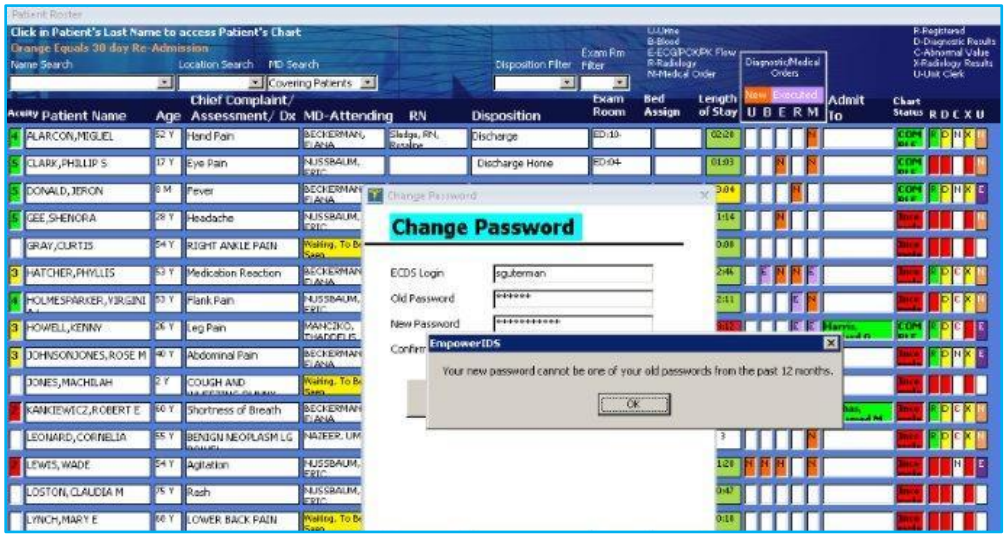
Password Complexity: Can require users to use upper/lowercase letters plus digits and punctuation.





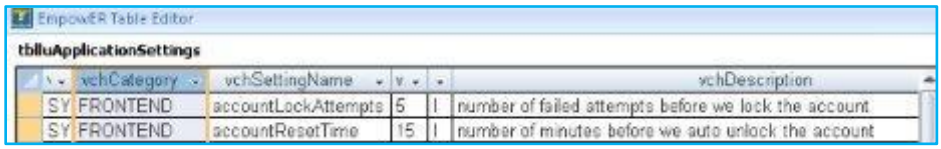


Maximum Number of Passwords Kept: Able to store 5 total, or for a 12 month period, whichever occurs first.



Force Password Change Based on Time Parameters: Can require users to update their password every 180 days.

Maximum Number of Login Attempts Before Access Blocked: Can set this to 5 attempts.


EmpowER Table Editor
tbluApplicationSettings
vchCategory
vchSettingName
vchDescription
SY FRONTEND accountLockAttempts 5 1 number of failed attempts before we lock the account
SY FRONTEND accountResetTime 15 1 number of minutes before we auto unlock the account

Auto-Lock Account after Predetermined Time Period: For example, 15 minutes.

Require User to Change Password Upon Resets: This can be set upon expiration of the user account

Chapter 9: Reporting and Data Mining

Empower Administrative Tools, or Admin Tools, provides a snapshot of the more common statistics. Designated Super Users can be provided with access to the Administrative Tools. These tools can assist administrators in identifying data that may need further analysis through other reports, available via the Report + Alert Writer. Custom reports can provide answers to virtually any data-driven question, and can be created by your Super Users or requested through your Project Manager if the complexity is outside the normal scope.

Empower Admin Tools track the following information, keeping in mind that all time flow studies are dependent on the accuracy of the entered data.

Operation Performance Index (OPI) Studies

- Daily Census
- Average Length of Stay of discharged patients
- Average Length of Stay of admitted patients
- Average time to triage patients
- Average time from waiting room to exam room
- Average time for a physician into an exam room
- Average time for a nurse to execute a diagnostic or medical order

Inpatient/ED Statistics

- Total discharges
- Total admissions
- Total admissions to Telemetry
- Total admissions to ICU
- Total admissions to Pediatrics
- Total admissions to Psychiatry
- Total admissions to General Medical floors
- Total left without being seen (LWBS)
- Total left Against Medical Advice (AMA)
- Total transfers
- ED stays greater than 12 hours
- Total city ambulance runs
- Total private ambulance runs

ED Log

- Triage time
- Patient name
- Gender
- Physician
- Nurse
- Diagnosis
- Medical record number
- Account number
- Disposition
- Disposition time

Using the complex report writer, specialized ED logs with any desired information, such as patient contact information or insurance information, can also be generated.

Naturally, the accuracy of any report is dependent on the quality of the documentation input to Empower. Education regarding both the data elements required and the reporting methods used in order to generate complex reports will be provided during the GoLive and Post GoLive phases of the Empower implementation. In addition, chart audits will provide education and feedback to the front end users about the quality of the documentation, which will further enhance the accuracy of Empower reporting.

Empower Report + Alert Writer

Perspective + Goals

As the technological advancements of Empower's ONC Certified EHR continue to evolve, our remains delivering user-friendly technology that allows our Inpatient, Ambulatory, and ED clients to be self-sufficient and independent in as many aspects of EHR administration as possible. Medical Order Sets, Hospital Forms, and Formulary Management are several of the core elements under the direct control of you, the Super User. In keeping with this philosophy, Empower is proud to announce that with respect to report and alert writing (aka Clinical Decision Support Rule) our clients can now design their own reports and alerts in an autonomous fashion. The goal is to minimize, and possibly eliminate, costs to the hospital for custom report and alert development. The end result of this initiative is to enable our clients to become self-sufficient and to avoid the added expense of external report writing software and 3rd party data mining services.

Convenient Accessibility

The Empower Report + Alert Writer is an integrated tool built on SQL Server Best Practices with a user-friendly front-end, allowing Clinical and IT leadership to write limitless reports and alerts, without the need for in-depth programming knowledge. Once reports are written, they can be run once or saved as recurring reports for future convenience.

The Empower Report + Alert Writer is a role-based tool which can be launched from within Empower by simply clicking the "Report Writer" button. The user will then choose either of the following options to launch whichever tool is desired.

1. Report Writer
2. Alert Writer

Powerful Functionality

Hospital staff with the designated Empower administrative rights can write any report or alert in real-time.

Examples of Reports

- Quality Reports
- Government Compliance Reports
- Operational Efficiency Reports
- Disease Management Reports
- Documentation Reports for Coding and Billing
- Meaningful Use Reports and Compliance
- Physicians Productivity Reports
- Hospital Staff Productivity

Examples of Alerts

- Myocardial Management, Compliance, and Contraindications Alerts (Beta Blocker, Door to Balloon Time, etc.)
- Congestive Heart Failure Management, Compliance, and Contraindications Alerts (Ace Inhibitor, etc.)
- Pneumonia Management, Compliance, and Contraindications Alerts (Appropriate Antibiotics)
- Stroke Management, Compliance, and Contraindications Alerts, etc.
- Surgical Care Improvement Project (SCIP) Management, Compliance, and Contraindications Alerts
- Disease Management, Compliance, and Contraindications Alerts (Diabetes HbA1C Tracking, etc.)

Setting Expectations

Each hospital and their staff will have different levels of proficiency with the Report + Alert Writer based upon familiarity of SQL functionality, hospital unit-specific clinical documentation methods, specialized clinical workflow, and related communication systems (hospital forms, medical order sets, etc.).

A realistic expectation is that hospital staff that are proficient with Empower EHR clinical documentation (front-end) and database (back-end) will be able to efficiently create a vast array of Reports and Alerts. Examples may include the following:

- Patient Lists with Medical Disease and Specific Diagnosis (MRSA, VRE Positive Patients)
- Patient Lists with Medical Disease Management Compliance
- Doctors Lists with Medical Disease Management Compliance
- Hospital Staff Lists with compliance of completing hospital forms
- Diagnostic Test: Lists of Abnormal Tests
- Hospital Forms Lists: Completed Forms (Restrains, Care Plan, etc.)
- Hospital Order Sets List based on Diagnosis Management and Compliance
- Alerts for Abnormal Vital Signs
- Alerts for Correct Antibiotics based on Diagnosis
- Alerts for Abnormal Diagnostic Test
- Alerts for Documenting Correct Coding Information
- Alerts for SCIP Compliance based on Type of Surgery

For hospital clinical and IT staff with minimal knowledge in SQL, Clinical Documentation/Workflow, and Database Structure requiring the following types of highly complex reports, the hospital may prefer to engage the Empower reporting team:

- Calculation Reports (i.e. reports involving time)
- Complex Clinical Documentation Reports
- Complex Workflow Reports
- Complex Communication Reports.
- Category Reports (Medications)
- Printing Reports, Faxing Reports, Email Reports

Recommended Knowledge Foundations

Empower's ONC Certified EHR participates in the practice of medicine between doctors and hospital staff by providing comprehensive clinical documentation services, complicated communication notifications, and supporting complex workflow systems. Empower recommends each hospital clinical unit (ICU, Telemetry, Labor & Delivery, Emergency Department, Pediatrics, etc.) designates a clinical administrator and an IT database expert to attend on-site training for the Empower Report + Alert Writer. This combination of clinical and technological expertise will assist both parties in mastering program functionality. In order to be proficient with the Report + Alert Writer, the hospital staff will need a basic foundation of SQL Server names and functions as well as Empower's database table structure. The SQL, or Structured Query Language**,** has a special purpose in programming language designed for managing and displaying data in relational database management systems. Prior to receiving web-based or on-site training, we recommend attendees read the publication "Teach Yourself SQL in 10 Minutes (3rd Edition)."

Training Options

Standard Introduction

Each Empower hospital receives 1 hour of complimentary web-based product demonstration and general training. Additional training is recommended in order to maximize use of the Report + Alert Writer.

On-Site Sessions

Hospitals can purchase on-site training sessions for 5 person groups of clinical administrators and IT staff led by Empower Report + Alert experts. On-site training delivers impactful results as clients receive hands-on experience with the product and detailed guidance by our experts. The $12,500 fee for this option includes five (5) business days of training at eight (8) hours per day.

Web-Based Sessions

If on-site training is not preferred due to staff's schedule limitations or a desire to invest in training over a longer period of time, intensive web-based training sessions are offered. Trainees benefit from the same Empower team of Clinical (physician/nurse) and IT experts, but in a remote setting accomplished by Hamachi VPN connection and Glance interactive web software. In addition, web sessions will be recorded and provided to clients so they can refer

back to key portions as needed. The cost for this training option is $225/hour and schedule options are very flexible.

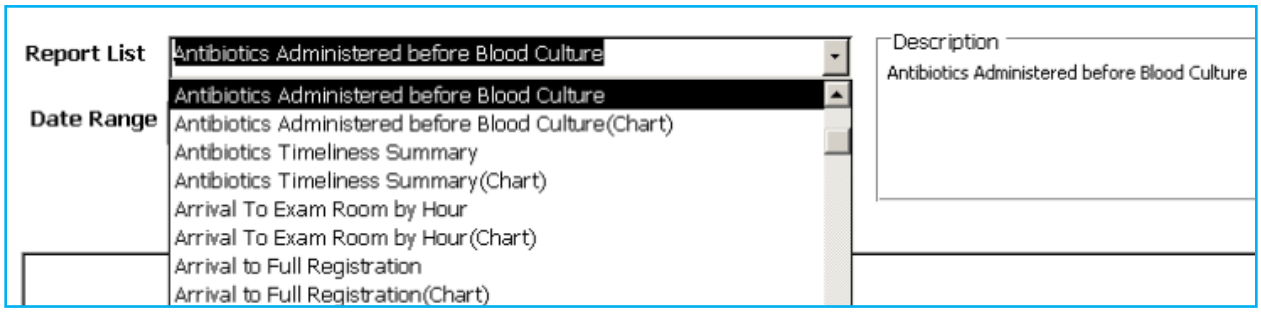
Delegated Option

While the Report + Alert Writer is an exciting tool for our clients, some may prefer to have Empower design highly complex reports for them. For this option, the standard rate of $225/hour applies.

Getting Started with Standard Reports

When administrative access is given, a Report Writer button will appear on the patient roster screen. When this program is launched, a list of reports will appear with their corresponding descriptions listed to the right, as shown below.

Report List View



Select a report from the drop down menu on the left, specify a start and end date, then select the Run button located to the right. Results are then displayed in a panel below.

Multi-Facility

If the facility has multiple sites, then a report can be generated which contains an additional field located below the date range that will list the names of all of the facilities. It cannot be left blank.

Reports

The standard reports are generally complex queries involving multiple tables, frequently containing many nested subqueries and multiple search criteria. The listing of reports presented in this overview reflects what is available as of this writing, but there are always more reports being developed and added. In general, new reports are created in order to address a generally accepted need among clients. Reports based on data in structured fields are more likely to be developed and implemented sooner than reports based on free-text fields. There are over one hundred different reports, as sample of which is listed below.

Standard Report Name		
72 Hour Returns	LWBS All	PCP Log
Admit/Transfer Statistics	LWBS Call Back	Pharmacy Usage
Ambulance Patients	LWBS Insurance	Pneumonia Antibiotic Timeliness
ASA Beta Blockers	LWBS Peds	Press Ganey Provider Dispositions
Audit Utilities	LWCT Conscious Sedation	Provider Efficiency
Business Reports	Messages	QA Conscious Sedation
Call Backs	Narcotics	QA Ortho
Conscious Sedation LWCT/AMA	Narcotics Rx	QA Restraints
Disposition Statistics	Non-Finalized	Registration Report
Disposition Statistics Peds	Non-Registered	Summary Statistics
Fast Track	Notifications	Time To MD Summary
Hourly Statistics	Nurse Efficiency	Triage Acuity Summary
Log	Nurse Patients	Zone Statistics

Ambulance Patient Report

The Ambulance Patient Report identifies all of the patients brought in by ambulance within a given time frame. It contains the following fields:

- ***Service Date:*** Date and time that the patient's record was started in Empower.
- ***Squad (Ambulance, EMS):*** The name of the ambulance provider that transported the patient.
- ***DOB:*** Date of Birth
- ***Age:*** Patient's Age
- ***vchPatientID:*** This field contains either the Empower generated patient ID or a number provided by the hospital's ADT system.
- ***MR#:*** Facility's medical record number
- ***Chief Complaint:*** This is the chief complaint as entered by the MD rather than from Triage.
- ***SS#:*** Social Security number.
- ***Dx:*** all of the diagnoses the MD makes on this visit.
- ***Insurance Name:*** all of the insurance companies that cover the patient.

ASA Beta Blockers Report

This reports the compliance with the aspirin and beta blocker protocol for acute myocardial infarction. The results of this report can sometimes be skewed by the actions of the first responders, who often administer these medications prior to arrival without subsequently entering that information properly into Empower. This can be corrected using manual overrides that reconcile the information without having to modify any patient data. While most of the fields in this report are self-explanatory items such as name, age, and gender, other report fields include:

- ***In Time:*** The time that the patient was added to Empower.
- ***Medical Record Number:*** The hospital's medical record number
- ***Account Number:*** The hospital's account number
- ***ASA Given****:* Yes or No
- ***Beta Blockers Given:*** Yes or No
- ***Include and Exclude:*** This will allow the user to record whether the patient was give aspirin, beta blockers, or both. This does not alter the record in any way, it simply instruct the program to omit or include that particular piece of information when calculating the statistics.

Calculations

Total MI Cases refers to the total number of patients diagnosed with acute myocardial infarction.

Both the ASA and the Beta Blocker columns contain two numbers. The first number is the total number of patients with acute myocardial infarction treated with the medication, the second number is the percentage of patients with acute myocardial infarction treated with the medication .

Disposition Statistics Report

The Disposition Statistics Report analyses the patient disposition data during a specified date/time range. Dispositions could include main ED discharges and admissions, and other areas such as fast track discharges and admissions. Performance statistics can be calculated for each category, with the exception of Left Without Being Seen, Registration Error and No Disposition.

Disposition Aggregates

- ***DispoType:*** The disposition category, such as admit, discharge or transfer.
- ***DispoTypeCount:*** The total number of patients counted in that category.
- ***Exclusions:*** The total number of patients whose data was not considered due to either manual exclusion or automatic exclusions.
- ***LengthOfStay_HrsMins:*** The average length of stay for patients in a specific category expressed in hours and minutes.
- ***Triage_HrsMins:*** The average length of time from the point that the Empower chart was started to the point that the triage note was started, expressed in hours and minutes.
- ***ExamRoom_HrsMins:*** The average length of time from the point that the Empower chart was started to the point that the patient was assigned to an exam room.
- ***DoorToMD_HrsMins:*** The average length of time from the point that the Empower chart was started to the point that the MD begins the patient assessment.
- ***MDToExamRoom:*** The average length of time from the point that the patient is placed in the exam room to the point that the MD begins the physical exam.
- ***Dispo_HrsMins:*** The average length of time from the point that the MD documents the physical exam to the point that the MD sets the patient's disposition.
- ***MDFinish_HrsMins:*** The average length of time from the point that the MD documents the physical exam to the point that the MD sets the chart ready to print.
- ***Print_HrsMins:*** The average length of time from the point that the MD sets the chart ready to print to the point that the chart gets printed.
- ***2SD_* columns:*** These are the second standard deviations of the raw average based on all data not excluded. Empower recalculates the average excluding any value that lies outside of the second standard deviation value. Those outside of the two standard deviations are flagged as outliers in the Disposition Data section.

Disposition Data

- ***Outlier:*** This result will be either NO or will have one or more codes indicating what indicator lies outside of the two standard deviations, such as ER, which would indicate ExamRoom, DMD, which would indicate DoorToMD, TR, which would indicate Triage, or LOV, which would indicate Length of Visit.
- ***Exclusion:*** Yes, or Y, if the record is excluded for any reason, otherwise N for No. This makes it easy to locate the specific records using a single filter.
- ***Negative Time:*** Yes or No. If a time calculation results in a value that is < -15 minutes, the record is marked as an exclusion.
- ***Triage Acuity:*** The triage level of urgency.
- ***TriageAcuityValue:*** The numerical equivalent of the triage assessment, ranging from high to low or vice versa, depending on preference.

- ***Disposition:*** The disposition type that the record was assigned based on the actual disposition.
- ***LengthOfStay:*** The length of time from the point that the chart was started to the point that the chart was printed, expressed in hours and minutes.
- ***Triage_HrsMins:*** The length of time from the point that the chart was started to the point that the patient was triaged, expressed in hours and minutes.
- ***ExamRoom_HrsMins:*** The length of time from the point that the chart was started to the point that the patient was placed in an exam room.
- ***DoorToMD_HrsMins:*** The length of time from the point that the chart was started to the point that the MD documented the patient's physical exam.
- ***MDStart_HrsMins:*** The length of time from the point that the patient was placed in an exam room to the point that the MD documented the physical exam.
- ***Dispo_HrsMins:*** The length of time from the point that the MD documented the physical exam to the point that the MD documented the disposition.
- ***MDFinish_HrsMins:*** The length of time from the point that time the MD documented the physical exam and the point that the MD sets the chart ready to print.
- ***Print_HrsMins:*** The length of time time from the point that the MD set the chart ready to print to the point that the chart is actually printed.
- ***Include and Exclude:*** Data can be manually included or excluded. This does not alter the record in any way, it simply instruct the program to omit or include that particular piece of information when calculating the statistics.
- ***Comments:*** This is a place for a reviewer to make any comments about a particular chart. These comments will be viewable and editable by other users, but the comments cannot be seen outside of the application. The field can contain up to approx. 4000 characters of information.

ED Hourly Statistics Report

The hourly statistics report shows the patient population for each hour of the day within any given date range. This provides a means of examining patient flow during the day. The report consists of a data grid, with each row in the grid corresponding to a single day and each cell in the row corresponding to an hour within that day. There are two buttons located about the data grid. One button is the Census View, which shows the total number of patients in the ED for each hour of the day. The other button is the In & Out view, which consists of an upper grid with the number of patients entering the ED during each hour, and a bottom grid with the number of patients leaving the ED during each hour.

Log

The Log is a listing of all of the patients that were seen in the ED during a specified time. Some definitions associated with this report include:

- ***Room:*** The exam room in which the patient was placed after triage. In some cases, rather than a room number, the symbol *WR* is displayed, indicating that the patient was sent back to the waiting room after triage.
- ***MOA:*** Mode of Arrival. The method (ambulance, police, walk in, etc.) in which the patient arrived at the ER.
- ***Triage Nurse:*** Triage nurse initials.
- ***Care Nurse:*** Primary nurse initials.
- ***First Nursing Note:*** Time of the first nursing note for the patient.
- ***First Phys Exam:*** Time that the MD performed the physical exam.
- **LWBS All and LWBS Peds Report**

The LWBS All report lists all patients with a disposition of LWBS, or Left Without Being Seen, within a specified time frame. The LWBS Peds report does likewise for pediatric patients.

What qualifies as an LWBS?

Patients who were entered into the system but left before they were seen by an MD may be legitimately tagged as LWBS. If a patients get to an exam room and then leaves, an MD may see the patients name listed in the exam room and, believing that a patient is there waiting to be seen, enter the patient's chart to look at the triage note. This will generate physician documentation for the patient despite the fact that the patient left and was never seen. At this point, the MD should simply set the disposition to LWBS and remove the patient from the tracker. MDs should not enter a repeat exam for these patients. A chart with both a LWBS disposition and a repeat exam is a documentation inconsistency that will cause the chart to be placed on the Non-Finalized report for review by administration.

MD Documentation: This field will have an "X" if there is a Physical Exam time in the patient's chart. It does not mean that there is a Repeat Exam. Any records on this report will meet the definition of an LWBS.

Narcotics Report

The Narcotics Report lists all of the narcotic orders in the ED. There is also a report for narcotic prescriptions. The report gives the patients name, the date of the visit, the medication given, the ordering physician, the dispensing nurse, and the order location, or where injection was given. It also lists whether the order was cancelled or refused, along with any nursing comments.

Non-Finalized Chart Report

Non-Finalized charts are inactive charts that are no longer on the patient tracking screen but were never printed. Other non finalized charts include:

- ***Improper assignment of LWBS or a LWCT patient:*** As mentioned earlier, the database makes certain assumptions about LWBS charts. Charts with the LWBS disposition and a repeat exam will flag the chart as a problem. In this case, charts should be set either LWCT (Left Without Completing Treatment), Eloped, Left Without Notifying ED Staff, Left AMA or anything else that indicates that the MD did in fact see the patient.
- ***Discharged patients on which charts were not printed:*** One common nursing practice is to print the patient's discharge instructions, discharge the patient, and then return later to complete the chart. This increases the possibility that charts will get removed from the patient tracking system without ever being printed. They will then show up on the Non-Finalized report.
- ***Inactive, non-printed charts with repeat exams:*** If a repeat exam is performed, the chart should then be printed or reprinted. Otherwise, it will appear on the Non-Finalized report.

Nurse Patients Report

The Nurse Patients Report identifies all of the nurses that documented on patient chart during a certain timeframe. Likewise, it can report all of the patients one which a single nurse documented during a certain timeframe. There are 3 possible roles a nurse might fill with a patient in the ED:

- ***Primary:*** The nurse recorded as the primary care nurse for the patient.
- ***Auxiliary:*** A nurse that documented on the chart other than the primary care nurse, such as charge nurses or float nurses.
- ***Triage:*** A nurse whose only documentation on the record is related to triage.

A nurse could conceivably be counted as both primary and triage, or auxiliary and triage. The primary and auxiliary roles take precedence over the triage role. A nurse will be listed only once for each patient and in the highest role applicable.

Pneumonia Antibiotics Timeliness Report

This report analyses compliance with the Pneumonia Antibiotics Protocol. The report analyses patients who were admitted to the hospital with a diagnosis of pneumonia, detailing the length of time from the patient arrival to the administration of the first dose of antibiotics. Therefore, the nurse must diligently document the time that the antibiotics were given, rather than the time that they were signed off on the chart. If antibiotics were given within 4 hours, the *< 4 hours* column will say '*Yes*.' If antibiotics were first given later than four hours, the *< 4 hours* column will say '*No*.' If antibiotics were not given, the *< 4 hours* column will remain blank.

Provider Efficiency Report

The Provider Efficiency Report looks at specific points in the patient flow for either physicians or midlevel providers. All of the fields in this report are identical to the fields with the same names in the Disposition Statistics Report, but are calculated on a 'per provider basis' rather than a 'per disposition basis.'

Summary Statistics Report

The Summary Statistics Report is a collection of printable reports. The Summary of Operational Statistics Report presents the aggregate data from the Disposition Statistics, Non-Finalized, LWBS and Pneumonia Antibiotics Timeliness reports in a printable format. Similarly, the Zone Statistics Report and Provider Efficiency Reports are printable versions of the aggregate data in the electronic reports of the same names.

Zone Statistics Report

The Zone Statistics report is designed for emergency department that are divided into zones. This report presents the same data as the Disposition Statistics Report, but breaks that data down by zone.

Meaningful Use Reports

As the Government is attempting reform the health care system, a set of standards has been established for Electronic Healthcare/Medical Records (EHR/EMR). The Office of the National Coordinator for Health Information Technology (ONC) enforces these standards. Empower has been Comprehensively Certified for its EHR (Inpatient, Ambulatory, ED) by the Drummond Group since 2010.

Using Empower's ONC Certified EHR allows users to be eligible for stimulus funds and incentive payments provided that Meaningful Use can be demonstrated. To monitor Meaningful Use, Empower has developed a real-time tool to measure and report Meaningful Use at different locations and settings. When the Meaningful Use threshold is met for a specific target, the report and generated numerical fields have a **Green** background. When a threshold is not met, the corresponding field is **Red**:

MU Threshold: Inpatient

Report Name	Meets Performance Instances	Eligible Instances	Performance Rate	Threshold
MUAM - Inpatient - Active medication allergy list	25	25	100	80%
MUAM - Inpatient - Active medication list	24	25	96	80%
MUAM - Inpatient - Advanced Directives	7	7	100	50%
MUAM - Inpatient - CPOE	22	25	88	30%
MUAM - Inpatient - Discharge Instructions	25	25	100	50%
MUAM - Inpatient - Electronic copy of patients record - 3 business days		0		50%
MUAM - Inpatient - Lab Results	21	21	100	40%
MUAM - Inpatient - Med Recon	23	25	92	50%
MUAM - Inpatient - Patient specific education	11	25	44	10%
MUAM - Inpatient - Patient summary record	25	25	100	50%
MUAM - Inpatient - Record Demographics	25	25	100	50%
MUAM - Inpatient - Smoking status	22	23	95.65	50%
MUAM - Inpatient - Up to date problem list	24	25	96	80%
MUAM - Inpatient - Vitals BMI Growth Charts	24	25	96	50%

MU Threshold: Ambulatory

Report Name	Eligible Instances	Meets Performance Instances	Performance Rate
MUAM - Ambulatory - Up to date problem list by Location	5	5	100
MUAM - Ambulatory - Active medication list by Location	5	5	100
MUAM - Ambulatory - Active medication allergy list by Location	5	5	100
MUAM - Ambulatory - Record Demographics by Location	5	5	100
MUAM - Ambulatory - Patient specific education by Location	5	0	0
MUAM - Ambulatory - CPOE by Location	5	0	0
MUAM - Ambulatory - Vitals BMI Growth Charts by Location	5	5	100
MUAM - Ambulatory - Smoking status by Location	5	5	100
MUAM - Ambulatory - Lab Results by Location	6	5	83.33
MUAM - Ambulatory - Electronic copy of patients record - 3 business days by Location	0		
MUAM - Ambulatory - Med Recon by Location	5	5	100
MUAM - Ambulatory - Patient clinical summary record by Location	5	0	0
MUAM - Ambulatory - Timely access via Internet by Location	0		
MUAM - Ambulatory - Generate and Transmit eRx by Location	0		
MUAM - Ambulatory - Patient Reminders by Location	2	0	0

Chapter 10: General User Manual

This is an overview of how information is captured within Empower Inpatient+Ambulatory™ in order to provide perspective to users whose primary purpose is acquiring information from, rather than entering information into, the Empower system.

INTRODUCTION

The Empower Inpatient+Ambulatory™ computer documentation system was created by clinically experienced physicians and nurses. The program merges technological information with medical information to create a real-time documentation system that improves communication and enhances patient flow. Empower has been recognized in the past as "a success story and role model" by the Joint Commission, and we continually monitor and adopt the changing Joint Commission standards in order to ensure continuing compliance. The system also ensures compliance by prompting the physician or nurse at various HCFA mandated junctions, electronically applying the physicians signature, and ensuring follow up by faxing the chart to the primary care provider or specialists office.

The program is dynamic and flexible, and can be customized to the needs of various physicians, nurses, and inpatient/ambulatory settings. Empower is also an inexpensive alternative to costly transcription or verbal documentation. This program, unlike others, is not template based, but rather is based on a single, free formed chart that is populated by the physician's or nurse's description of the patient's history, physical exam, diagnostic tests, medical orders, and clinical summary to provide an accurate EMR, or electronic medical record.

The Empower chart reflects the company's philosophy of 'One patient, One Chart, One Database.' There is no need to collate several separate charts or pieces of charts into one record at the end of the patient encounter. Empower provides all the tools necessary in order to document the patient's clinical information while simultaneously caring for the patient. The software is written such that it follows the patient stepwise through the healthcare system, beginning with the registration process and ending with the discharge instructions.

Navigation

Starting the Empower Inpatient+Ambulatory™ Program

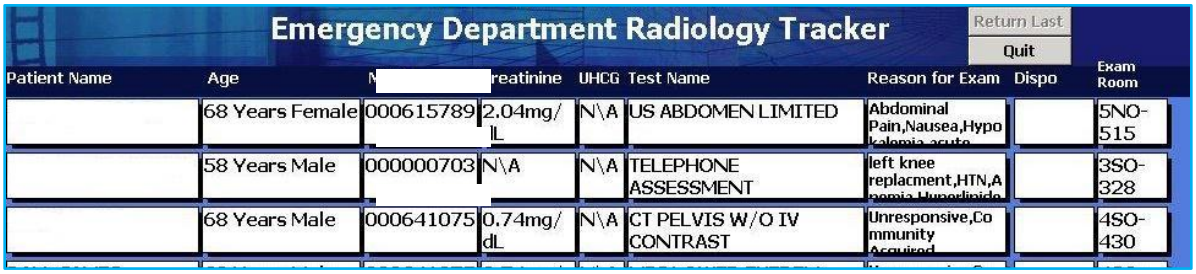
- Click on the **EmpowerSystems™** icon on the desktop.
- Log In with the ID provided by your system administrator.

Patient Tracking Board (Universal View)

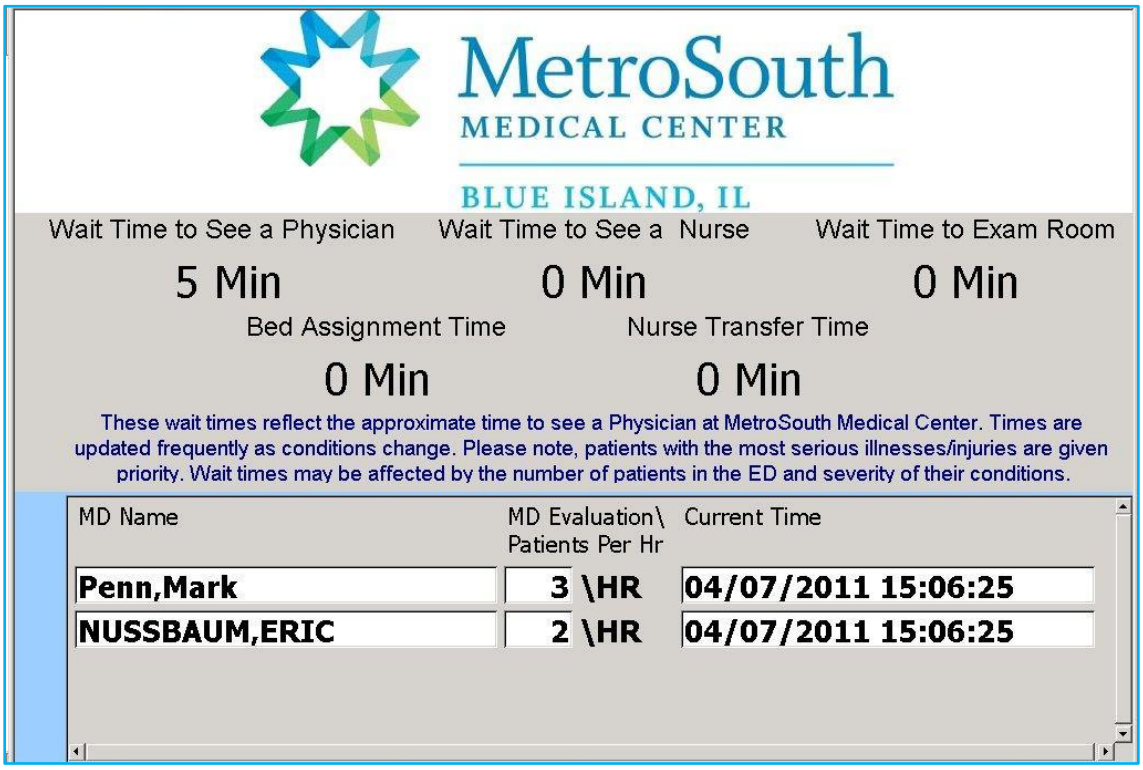
The opening screen is the Patient Tracker, which lists all of the active patients. This tracker can be configured to meet the needs of nearly any department. It can list the patient's name, room number, the treating or primary physician, the primary nurse, the disposition, the number of hours that patient has been in the hospital, or many other pieces of data. It also contains indicators that detail the registration, diagnostic, and order status. The initials of the physician and primary nurse caring for the patient are displayed alongside the name of each patient. The tracker provides a conduit to a nearly any location in the patient's chart, and can be customized or modified as the need arises.

Examples of Trackers

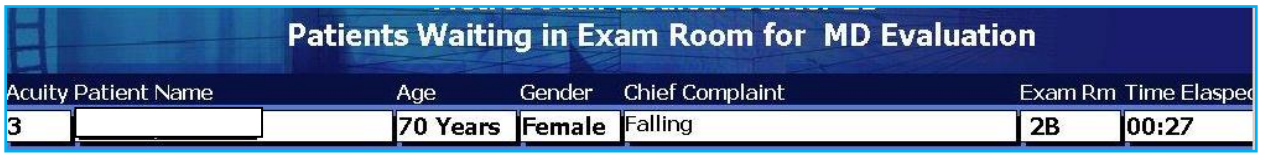
Radiology



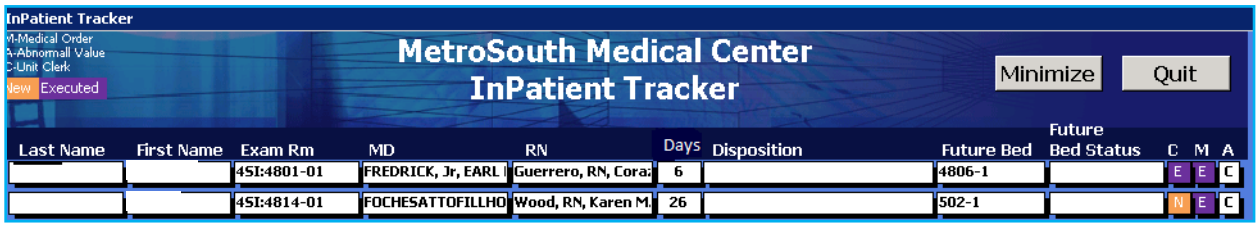
Provider Efficiency


MetroSouth
MEDICAL CENTER
BLUE ISLAND, IL
Wait Time to See a Physician
Wait Time to See a Nurse
Wait Time to Exam Room
5 Min
0 Min
0 Min
Bed Assignment Time
Nurse Transfer Time
0 Min
0 Min
These wait times reflect the approximate time to see a Physician at MetroSouth Medical Center. Times are updated frequently as conditions change. Please note, patients with the most serious illnesses/injuries are given priority. Wait times may be affected by the number of patients in the ED and severity of their conditions.
MD Name
MD Evaluation\ Patients Per Hr
Current Time
Penn,Mark
3 \HR
04/07/2011 15:06:25
NUSSBAUM,ERIC
2 \HR
04/07/2011 15:06:25

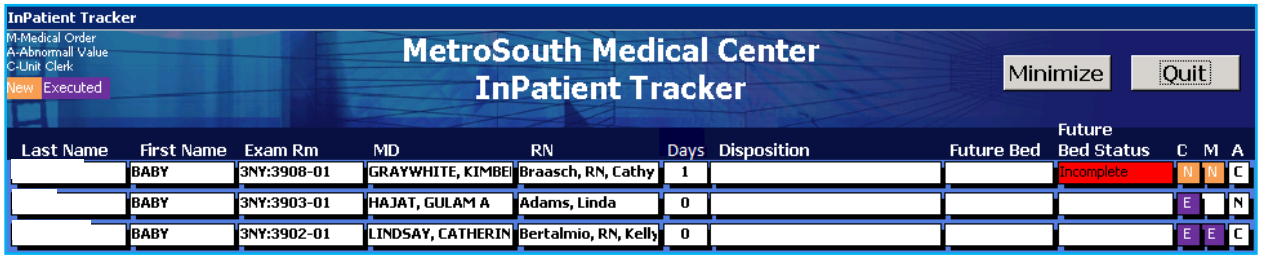
Waiting Room



ICU



NICU



Registration

Security

For Administrative and Clinical users, the tracker will have active control buttons to launch different aspects of the program. These grey control buttons at the bottom of the screen are user specific and are determined by the system administrator. They allow users to perform various tasks such as to adding or deleting patients, adding or deleting staff, changing passwords, accessing old records, or many other desired functions. Examples of these functions include,

- **Add Patient** allows patients to be added to Empower. It also bypasses the live system interface, so patients can be added during system down time, and test patients can be added for educational or demonstration purposes
- **Admin Tools** provides administrators access to specific non-clinical functions.
- **Change Password** allows a user to change their password at any time. Every user is expected to understand that their password is their electronic signature, and must be protected at all.
- **Log Out** should be used whenever the documentation is completed or the workstation is not in use.
- **Old Records** allows previous charts to be viewed. Users can search by a patients name or partial name or their medical record number.
- The **Current User** is displayed at the bottom left corner of the tracking board.

Documentation Methods

The four types of fields used for Empower documentation are:

- **Drop-down Boxes** that allow users easily to scroll through tables by typing the first few characters of the desired word. If a particular word is not found, information can be free texted.
- **Multi-select Boxes** function like a drop-down box, but also allow words to be strung together.
- **Check Boxes** simply let the user check a prewritten statement or field.
- **Free-Text Fields** allow information to be manually entered via keyboard or voice-recognition technology.

The system automatically populates all time fields with the time that the data was entered. The time fields can be changed to reflect different times by clicking in the time field and entering the corrected time using military or twenty four hour format.

Physician Note

This page contains the current physician note, consults, latest vital signs, and other information. There is also a Physician Note List that lists all previous SOAP notes. This area can also be filtered.

History/Subjective (Provider)

The fields in this area that are highlighted in blue are required to be complete by government agencies for risk management safeguards and correct physician billing. Acronyms used are common and include

- PMHx = Past Medical History
- SoHx = Social History
- FmHx = Family History

Admission/Assessment (Nurses)

The nursing staff documents the above listed histories, and also the patient's allergies, current and previous medications, skin integrity, nutrition status, advance directives, and fall, DVT, and self harm risk assessment in this area. The language of documentation can be customized to suit Joint Commission terminology and any particular preferences of the patient care setting.

Exam/Objective (Provider)

This area documents the patient's physical exam. There are check boxes that allow the physician to enter a normal exam statement, multi select fields that provide pre-written abnormal findings, and areas for free text entry. Repeat Exams are required prior to completing a chart.

Lacerations/Procedures (Provider)

Laceration repair and other procedures are documented by the physician in this area in language appropriate for coding. Free-text entry is again permitted.

Diagnostic Results (Provider and Nurse)

This screen contains diagnostic laboratory results and it also contains a link to the PACS radiology system. Results will auto-populate into the field when the laboratory interface is active. Some of the fields have a diagnostic interpretation area for the physician to complete, as such completion is sometimes required for correct physician billing. The auto populated results will not overwrite the provider's interpretation. The results can be filtered, and in addition to the results, this screen also lists both the time that the specimen was collected by the staff and the time that the specimen was received by the laboratory.

Assessment/Plan Medical Orders (Provider and Nurse)

The first patient assessment will come from the subjective section of the patients chart. Subsequent assessments can be entered by the providers. When the assessment is selected from the list, the site-defined codes will also be included in the PDF Chart.

Common diagnostic orders are placed by checking the box near the name of the test. Less common studies are ordered from the Diagnostic Orders drop down box, and pharmacy orders are also selected from the corresponding drop down box. Non-standard orders can also be selected or free texted in the Other Medical Orders and Comments. Standard Order Sets are specific sets of diagnostics and, in some cases, treatments that can be ordered with a single check box. These sets are hospital specific and can also be selected from a drop down list. In addition, if the physician chooses to admit the patient, the admission orders can also be selected individually or in order sets.

Location and Response of IV Insertion or Insertion of Drains on the Input Form, Output Form, or Nursing Notes allows the nurse an area to document the details of these procedures. The nurse is prompted for certain required information, such as the IV completion time, before closing the chart. Only a nurse or Unit Secretary can document cancelled or refused medical orders by clicking on the respective medical order status field. If an order is placed by a nurse, she must also assign a provider to this order. The provider will then be prompted to sign these orders prior to completing the chart.

Clinical Notes (Nurse Enters/MD Views)

This is divided into two sub-forms:

I. Clinical Notes, a personalized form that includes Chief Complaint, History, Limited Nurse Physical Exam, and Government Agency and JCAHO required documentation
II. Vital signs

Nurses' notes are displayed in chronological order. Documentation is completed by using either site-specific phrases or free-text entry. The institution can also create forms for documentation which can also replace pre-printed paper forms and protocols currently in use.

Vital Signs (Nurse Enters/MD Views)

By clicking on the vital signs and the pop-up box, vital signs can be viewed and entered. These can also be trended. A patient monitor interface can be used and the latest vital signs from the monitor will be displayed for viewing and any needed correction prior to saving. The nurse is

alerted to any abnormal vital signs and returned to this screen, allowing the nurse to repeat the vital signs or consult the physician regarding the patient condition prior to discharge.

Intake (Nurse enters/ Provider Views)

These values can be filtered and totaled during different time frames.

Output (Nurse enters/ Provider Views)

These values can be filtered and totaled during different time frames.

Scan/View Scan (Physician and Nurse)

Previous scans can be viewed from any computer, and those computers directly connected to scanners can also scan documents into the system.

Pharmacy RN Tasks (Physician and Nurse)

Medications ordered and dispensed are documented and displayed in this area. If a pharmacy interface is used, this information can be auto-populated.

Print Orders (Physician and Nurse)

Prints a hard copy of all diagnostic and medical orders. This can be used at the bedside to verify a patient identity, by unit secretaries to enter orders or transmit orders to ancillary departments.

Notifications (Physician and Nurse)

The physician or nurse can document the notification of other physicians, consultants, or other agencies. Response time can also be documented.

Discharge Instructions (Physician and Nurse)

Discharge Diagnosis is imported to this screen from the provider's assessment. Diet, activity, and any other instruction are also chosen. The patients follow up physicians, complete with address and phone numbers, are also assigned. All instructions are available in different languages.

Discharge RX- Prescriptions (Physician)

The physician can select prescription medications by clicking on an empty box in the Home Medication section. Typing at least two characters into the pop up box will prompt Empower to access the medication database, and as more characters are typed, the program will drill

down to more specific options. Selected prescriptions print with an electronic signature when the nurse prints the chart. Prescriptions can also be faxed or E-Prescribed.

Finalize Chart (Physician)

When the disposition is complete the physician can select the 'Finalize Chart' button. This prompts the risk management features to scan the chart for incomplete documentation and allows the physician to view the estimated level of service assigned to the chart. The physician can then review the documentation and make any required additions or corrections prior to completion of the chart.

Print (Nurse)

After the physician finalizes the chart, the nurse can print the entire chart by clicking the 'Print Menu' button and then selecting the 'Print All' button. All previously printed or temporary hard copies of the chart should be discarded in accordance with Medical Records policies. The nurse can also print the Clinical Summary or Medication Reconciliation page for the patient to keep, in accordance with Meaningful Use guidelines.

Chapter 11: Nurse/Medical Assistant User Manual

The Empower Inpatient+Ambulatory™ computer documentation system was created by clinically experienced physicians and nurses. The program merges technological information with medical information to create a real-time documentation system that improves communication and enhances patient flow. Empower has been recognized in the past as a success story and role model by the Joint Commission, and we continually monitor and adopt the changing Joint Commission standards in order to ensure continuing compliance. The system also ensures compliance by prompting the physician or nurse at various HCFA mandated junctions, electronically applying the physician's signature, and ensuring follow up by faxing the chart to the primary care provider or specialist's office.

The program is dynamic and flexible, and can be customized to the needs of various physicians, nurses, and inpatient/ambulatory settings. Empower is also an inexpensive alternative to costly transcription or verbal documentation. This program, unlike others, is not template based, but rather is based on a single, free formed chart that is populated by the physician's or nurse's description of the patient's history, physical exam, diagnostic tests, medical orders, and clinical summary to provide an accurate EMR, or electronic medical record.

The Empower chart reflects the company's philosophy of 'One Patient, One Chart, One Database.' There is no need to collate several separate charts or pieces of charts into one record at the end of the patient encounter. Empower provides all the tools necessary in order to document the patient's clinical information while simultaneously caring for the patient. The software is written such that it follows the patient stepwise through the healthcare system, beginning with the registration process and ending with the discharge instructions.

Empower Inpatient+Ambulatory™ Nursing/MA Documentation

Starting the Program

- Click on the Empower icon on the desktop.
- Log In is provided by your system administrator.
- The Patient Tracker will appear as the opening screen.

Empower Inpatient™ Patient Roster

Patient Roster
Click in Patient's Last Name to access Patients's Chart
Click in Patient's First Name to remove the patient
Name Search
Location Search
ED
MD Search
Disposition Filter
Exam Rm Filter
U-Urine
B-Blood
E-ECG/POX/PK Flow
R-Radiology
M-Medical Order
Diagnostic/Medical Orders
New Executed
R-Registered
D-Diagnostic Results
C-Abnormal Value
X-Radiology Results
U-Unit Clerk
Acuity Patient Name Age Chief Complaint/ Assessment/ Dx MD-Attending RN Disposition Exam Room Bed Assign Length of Stay U B E R M Admit To Chart Status R D C X U
3 67 Y Leg Pain WATSON, RICHARD Carr, Dawn R Discharge Home ED:Hall 15- 15 03:27
3 55 Y Near-Syncope NUSSBAUM, ERIC McDonald, Vicki RN Admit observation ED:03- 452-1 03:46

The following columns appear on the tracker, and can be modified as desired:

Acuity is based on the Emergency Severity Index (ESI) 5 level system. Empower also has customizable tables for hospitals that use a different system. The ESI 5 level is assigned in Triage:

ESI Level	CATEGORY	COLOR
1	Resuscitation	RED
2	Emergent	RED
3	Urgent	YELLOW
4	Not urgent	GREEN
5	Referred	GREEN

Patient Name appears on the tracker when entered by the ADT interface or the 'Add a Patient' button.

Age appears on the tracker when the date of birth is entered by the ADT interface or the'Add a Patient' button.

Chief Complaint is initially populated with the complaint entered by the ADT. It is updated by the chief complaint from the Triage Clinical Note and fianlly replaced by the chief complaint on the physicians note.

MD Name identifies the doctor caring for the patient with the physicians initials.

RN Name identifies the primary nurse caring for the patient. By double clicking in this box, a pop up screen will appear with the list of nurses' names. Clicking on the appropriate name will set the corresponding initials to appear in the box. The initials will also populate any orders or notes entered. This field should be updated when the primary nurse is changed.

Disposition is entered by the doctor or nurse on the discharge screen and populated into this field.

Exam Room is populated with the room number from the triage clinical note unless another room number is entered by clicking on the box and selecting a room.

Bed Assignment provides an area to enter the inpatient room number where appropriate. It also functions as a "sticky note", by clicking on the box a pop up field appears that allows 18 characters of free text which will also appear on the tracker. This can be used to notify of ISOL or other information.

Time in ER in Hours and Minutes. The box appears Green for patients who have been in the department less than three hours, Yellow for patients who have been in the department for more than three but less than five hours, and Red for patients who have been in the department for more than five hours.

Diagnostic and Medical Orders has five columns, each with one of the following designations:

- **U** = Urine
- **B** = Blood
- **E** = EKG and other diagnostics like Pulse Ox & Peak Flow.
- **R** = Radiology
- **M** = Medical Interventions like an IV or medication.

When orders are entered, an Orange box with the letter N, for New, is displayed in the box. When the order has been completed, the box turns Purple and displays the letter E to reflect that the order has been executed.

The **R, D, C, X, U columns** are interface columns and reflect the following chart status issues:

- R = Registration, this box will display green when the full registration process is complete.
- D = Diagnostics, this box will display yellow when all diagnostic tests are complete.
- C = Critical Values, this box will display a red C to notify clinicians of critical/abnormal lab values.
- X= Radiology Results, box will display yellow when a radiologic study is completed and uploaded into the PACS system
- U= Unit Clerk, when the Unit Secretary signs off on orders that have been entered in the Core system (CPOE is not active) or checks to make sure orders cross into the Core system.

Admit To displays the name of the doctor to whom the patient is admitted.

Chart Status appears **Red** while the chart is incomplete, or **Green** when ready for disposition. When the physician finalizes the chart, Empower's risk management functionality scans the chart and provides prompts for the physician to complete all necessary documentation. Doing so will change the status box to Green and the word 'ready' will appear inside of the box, after which the nurse can Print and close the chart. The nurse is likewise prompted to complete any required documentation prior to completing the chart.

Filtering/Sorting the Tracker

Filters can be applied to limit the patients displayed selecting from the drop-down fields 'Name Search', 'Location Search', 'MD Search', 'Disposition', or 'Exam Room'. To remove any of the filters, select 'All' from the drop-down fields.

Sorting can be done on any column by right-clicking and choosing a sort option.

Patient Name appears on the tracker when generated by the ADT interface or by using 'Add a Patient.'

Age as entered when date of birth entered by the ADT interface or by using 'Add a Patient.'

Gender as entered by the ADT interface or by using 'Add a Patient.'

New/Established is populated by clicking on the box once. Who will do this will be determined by your workflow.

Exam Room is populated by clicking in the box once. Who will do this will be determined by your workflow.

Appointment Time/Appointment Status entered by the ADT interface or by clicking in the box (Appointment Status only)

Time in Office is calculated in minutes when the patient is placed on the Roster.

Triage is answered by clicking the box and choosing the correct answer. This can be used to communicate with the practitioner that the patient is ready to be seen.

Complaint/Message is populated by clicking on the box once. This area is free text.

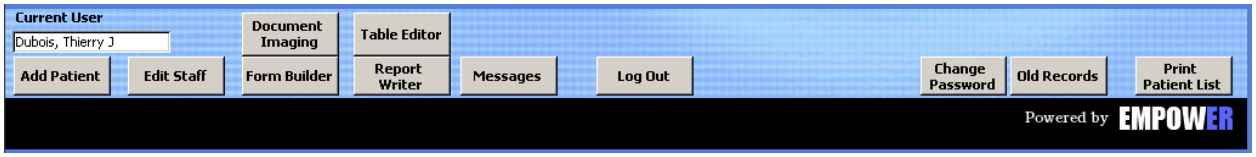
MD Name column identifies the doctor taking care of the patient by their name via dropdown menu.

Disposition is entered by the doctor on another screen.

Orders: When new orders are entered, an **Orange** box with an **N** is displayed. When the order has been noted Complete, the box turns **Purple** with an E to reflect the order has been executed.

Filtering /Sorting the Tracker: Filters can be applied to show a Patient Name who has been put on the Patient Roster.

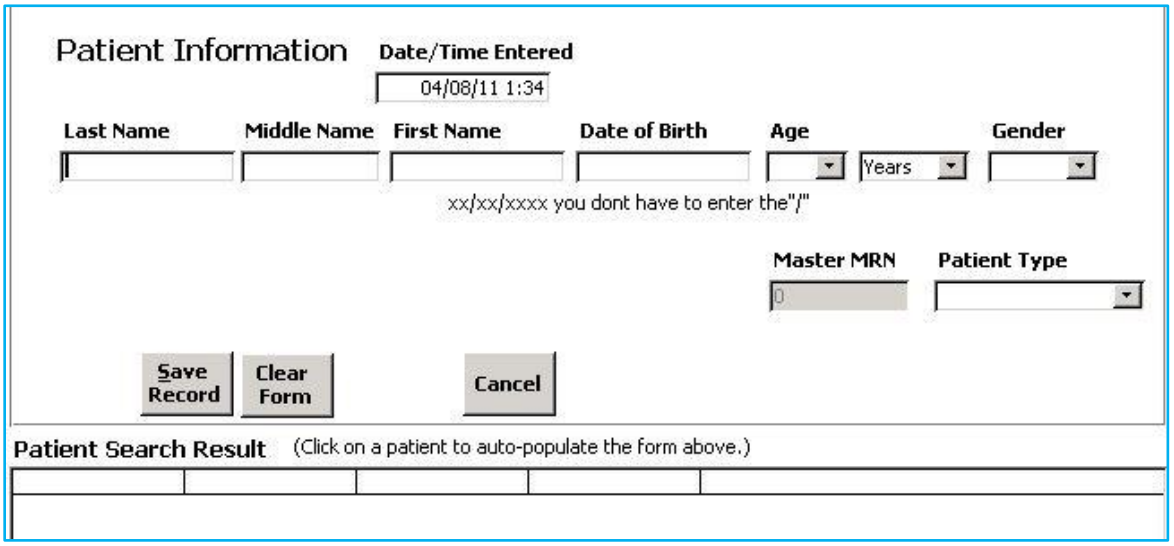
Empower Patent Roster Buttons



Depending on the level of access, less buttons will be available

Current User: This displays the current person logged into the system.

Add a Patient



In the 'Live' environment the patient names will be entered into the hospital core HIS system or Practice Management software using a short registration, which will flow via the interface into the Empower Patent Roster. If the interface is not Live or there is a core HIS downtime, this method can also be used.

For education and in the 'Test' environment, users can enter patients using the 'Add a Patient' button in the lower left of the Patient Tracker screen.

Click the 'Add a Patient' button and enter the name, birth date (age will automatically populate) and gender. If the patient has previously been in the hospital system, their demographic information will already be in the database. Click 'Save Record' and the Triage screen will open. The Medical Record Number can be added later and is a required field to close the chart.

If the patient cannot be found, this is a new patient to the database. For new patients; enter the name, birth date (age will automatically populate) and gender. Click 'Save and Record' and Empower will generate a new Medical Record.

After Clicking Save and Record, the staff member will be taken to the Demographics section in Empower.

Old Records

On the Patient Tracker screen click 'Old Records.' Type in a patient name or portion of the name, or a MR number and click 'Search.' Click on the desired name/visit date and on the bottom click 'View PDF Chart' to view a chart. Click 'View Patient's Empower Chart' to view the Empower record. 'Return to Tracker' can be clicked if the patient was inadvertently removed.

Addendums can be made to the chart in 'View Chart' by the Nurse in the Nurses Notes or the Physician in the Repeat Exams at any time. After any changes are made, the electronic PDF chart will need to be regenerated by highlighting the patient record in 'Old Records' and click the box to regenerate the PDF, which is the official patient medical record.

Addendums to any other area of the chart must go through administration or medical records so the chart can be opened (unlocked). If this is deemed necessary, Empower will contact and coordinate and provide step-by-step instructions to complete this.

Administrative Tools

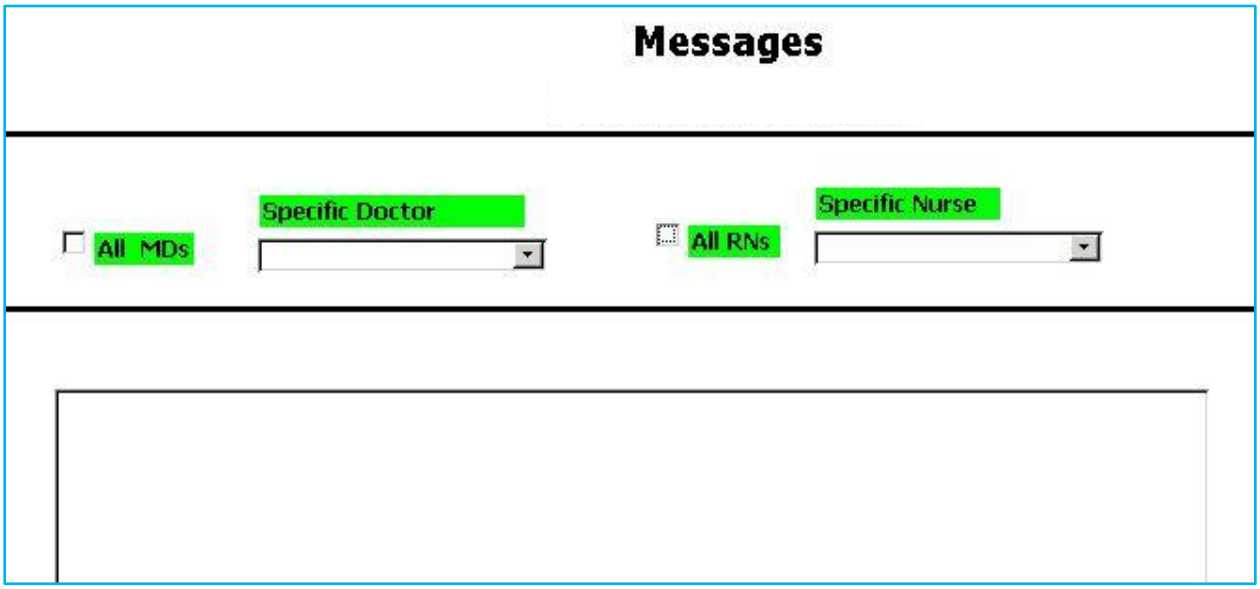
The use of these tools is designed for the clinic's Empower administrators and designees for data collection and will be taught in detail by Empower Training Specialists during Go Live.

Edit Staff: This button is used by administrators to add new associates or change the level of access for current associates. For deleting associates, please make them Inactive.

Form Builder: This button is used to build forms for Clinical Notes. These are the forms and templates available in Clinic Notes/Nursing Notes section. Super Users will have training on this feature prior to Go Live.

Table Editor: This button is used to manipulate certain tables add or delete items. Please see Appendix 9A for the list of tables.

Messaging: Empower has an internal email system used to communicate to other Empower users. The 'Messages' button gives the user access to this function. The recipient must acknowledge that they have READ ALL MESSAGES immediately when they first login prior to taking care of patients. This ensures that every user must read and acknowledge all policy and procedure changes and will not be able to use the system until they have. Instructions for an admin user to send a message are as follows:



- Click on MESSAGES.
- Select the Nurse or Doctor from the drop down list OR select ALL.
- Click in the white box and compose your message.
- Click SEND.
- If you have a MESSAGE, this screen will be the first to appear after you log in.

An audit of these Messages is available in the Empower Report Writer for reference.

Note: This message functionality is designed for internal policy communications and will not function or connect to any other email system.

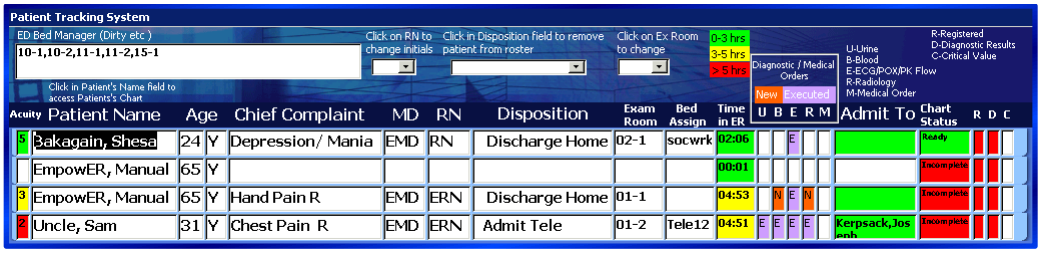
Duplicate Patients

Inevitably, for whatever reason, there will be a duplicate patient record. There are two major concerns to be acknowledged and one way for them to be expeditiously addressed in Empower.

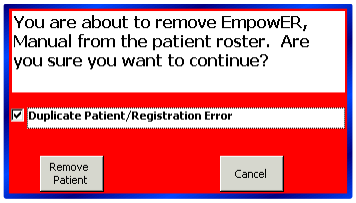
1. Orders with an erroneous account number will fail to interface.
2. Empower does not and will not provide merge functionality for clinical data.

The following process will quickly and easily remove the erroneous account so clinical data is ONLY entered on the one record and provide a solution to correct/update demographics.

Below is an example of a duplicate patient “Empower, Manual”. It is easy to identify the top chart is in error by the amount of time on the Roster and the lack of information.

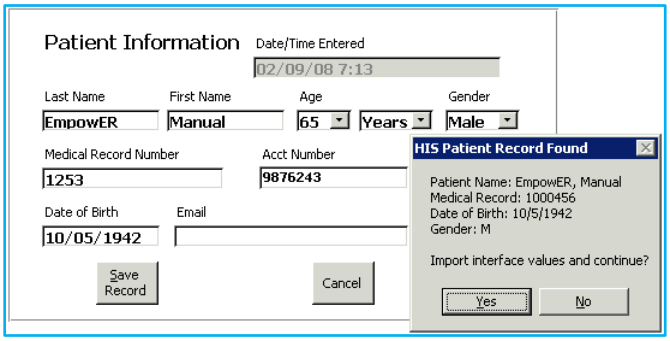

Patient Tracking System
ED Bed Manager (Dirty etc.)
10-1,10-2,11-1,11-2,15-1
Click in Patient's Name field to access Patient's Chart
Click on RN to change initials
Click in Disposition field to remove patient from roster
Click on Ex Room to change
0-3 hrs
3-5 hrs
> 5 hrs
Diagnostic / Medical Orders
New Executed
U-Urine
B-Blood
E-ECG/POX/PK Flow
R-Radiology
M-Medical Order
R-Registered
D-Diagnostic Results
C-Critical Value
Acuity Patient Name Age Chief Complaint MD RN Disposition Exam Room Bed Assign Time in ER U B E R M Admit To Chart Status R D C
5 Sakagain, Shesa 24 Y Depression/ Mania EMD RN Discharge Home 02-1 socwrk 02:06
EmpowER, Manual 65 Y 00:01
3 EmpowER, Manual 65 Y Hand Pain R EMD ERN Discharge Home 01-1 04:53
2 Uncle, Sam 31 Y Chest Pain R EMD ERN Admit Tele 01-2 Tele12 04:51
Ready
Incomplete
Kerpsack,Jos

Upon this discovery, immediately click in the ‘Disposition’ column to remove the erroneous chart from the tracker.


You are about to remove EmpowER, Manual from the patient roster. Are you sure you want to continue?
Duplicate Patient/Registration Error
Remove Patient
Cancel

Checking off 'Duplicate Patient/Registration Error' will prevent this record from being included in the ED's statistics.

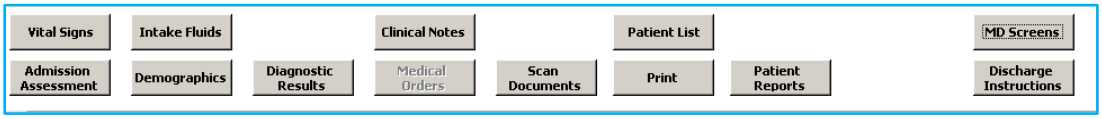
To correct the demographics in case the original clinical chart was in error, go to the 'Patient Demographics' screen in Empower and enter the correct Account Number. If Empower has received an interface message with the same account number, you will receive a message similar to the following:



The Import/Update Demographics function can be used on any active patient in Empower.

Open the Patient Chart: Click on the Patient Name and the chart will open to the Medical Orders screen.

Gray Control Buttons: At the bottom of each screen you will see gray buttons. Click on these buttons to move through the various portions of the chart. Each one acts as a 'Save' button from the current screen.

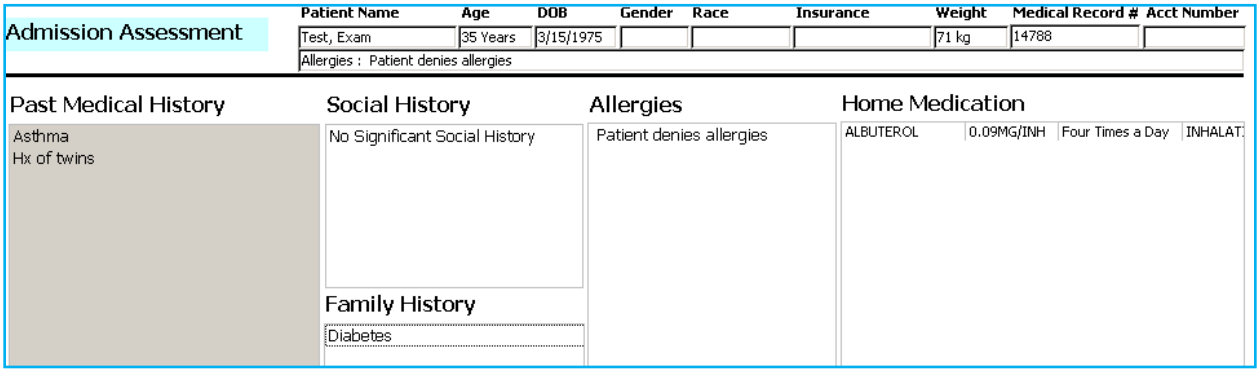


Vital Signs

Admitting Weight and Height: This is the weight of the patient on their initial visit. Click the box to enter information. Information can be entered in kilograms or pounds.

Visit Vital Signs are entered by single clicking the any box in the empty row (1st). A new Vital Sign box will open and information is entered by clicking in the specific box or using the tab button to progress to the next box.

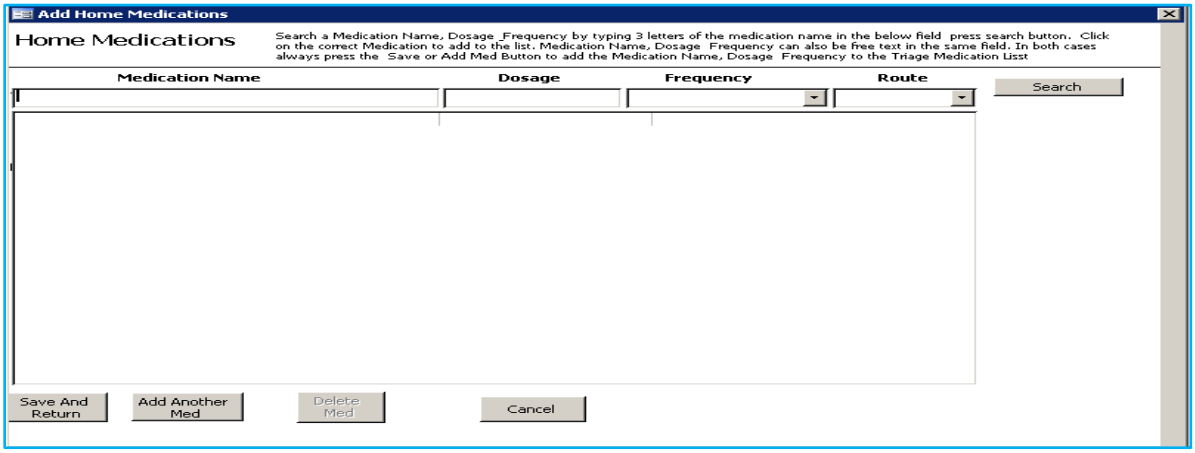
Admission Assessment



This includes all pertinent information to begin care of the patient. Fill in all pertinent fields by double-clicking on the specific box. Past Medical History, Social History, Family History, and Allergies are added by single clicking on them from the list on the left. The box on the bottom can be used as a drop down table or free text. Information required for Meaningful Use is also required in Empower.

Selected situations can be commented, changed, or deleted by double clicking on the text. After information is satisfactorily completed, click on the Save button

Home Medication: Clicking on this field will open a Home Medication window. Clicking on the first empty row will open the Add a Medication Window.


Add Home Medications
Home Medications
Search a Medication Name, Dosage Frequency by typing 3 letters of the medication name in the below field press search button. Click on the correct Medication to add to the list. Medication Name, Dosage Frequency can also be free text in the same field. In both cases always press the Save or Add Med Button to add the Medication Name, Dosage Frequency to the Triage Medication Lisst
Medication Name
Dosage
Frequency
Route
Search
Save And Return
Add Another Med
Delete Med
Cancel

Start typing the Medication Name, after two characters, a drop-down menu will appear. The more characters types, the more specific the options become. This will give a list of the medications in our databank with different dosages. Choose the medication, dosage, and route most appropriate by single click. The boxes with an error require a choice from a pre-populated list.

When satisfied, click Save and Return to return to Home Medication or click 'Add Another Medication' to do so. In the Home Medication Window, push the Save Button to return to the Admission/Assessment page.

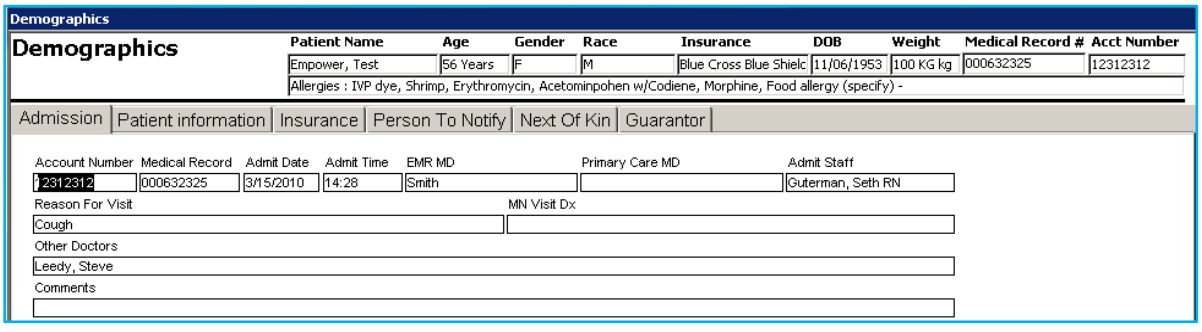
Allergies/Medications: It is imperative to select the from the drop-down list as the Empower Smart Technology features include allergy detection and cross-reactivity. Although free-text is allowed for the rare medications/substances not included in the tables, Empower may not identify potential allergies or Drug to Drug Interactions.

Intake Fluids

In this area, anything given to the patient is documented. To enter medication, single click on the first empty row. The new window called Intake Documentation opens. Empower will automatically time stamp, but this can be changed if needed by clicking in the box. The Medicine/Device Type is the name of what is given. This is a dropdown menu with no free text. Dosage/Rate is for infusion therapy (IV). Route/Site is how the medicine is given. Amount is free text with the unit type after. Residual is any amount wasted. The comments section is the area where site, lot number, and expiration can be documented.

Demographics

This button will open a window with different tabs. If the ADT Interface is active, it should be populated. The information can be entered manually.



Admissions: This tab will give information about PCP, Consults, and reason for the visit.

Patient Information: As noted by the name, this is where the patient's Address and Employer is entered.

Insurance: Clicking on the open spot will open a second window where the patient's Insurance information is entered. For patients with multiple insurances, 'Add Another Repeat Exam' is used to add until complete. Click 'Save and Record' when completed.

Person to Notify: This tab is used to enter Power of Attorney information.

Next of Kin: This tab is used to enter Next of Kin, as sometimes, it is not the same as Power of Attorney. Individual clinics will determine which will be used if it is the same.

Guarantor: This information is usually reserved for Pediatric patients or Workman's Compensation

Diagnostic Results

Diagnostics are those tests done to determine what is wrong with the patient. These tests results will either come from the hospital, scans, or entered in the office. Use the PACS button to connect to the hospital to review the actual image.

To view a result, single click on that result.

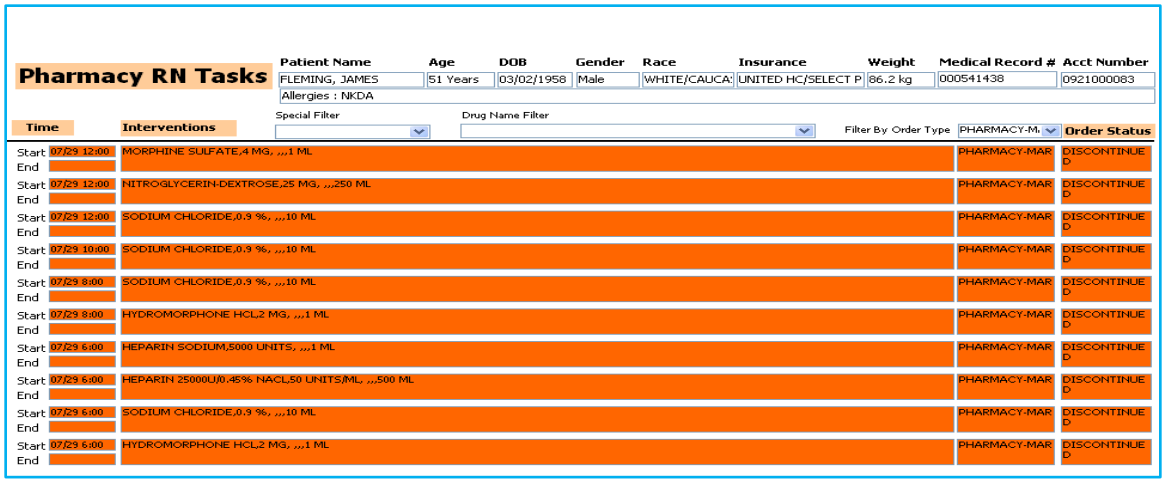
To enter a result, click on the 1st line (empty). A second window will open up. The nurse has the option of free texting or choosing the Diagnostic Name from the drop down menu. The result can also be entered in the Diagnostic Interpretation via free text or the drop down menu.

Results can be filtered using the drop down menu. Keep in mind that if a test was not performed, it will not be in the drop down.

PHARMACY/RN Task

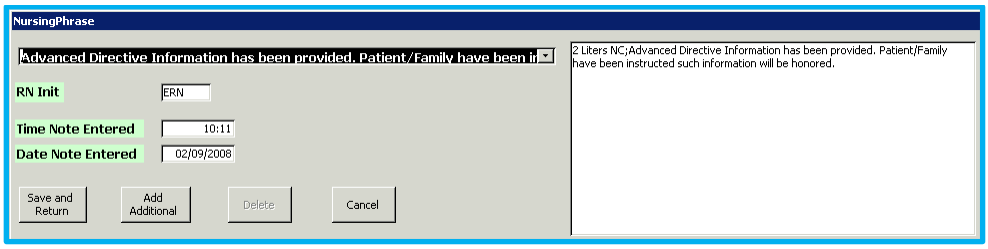
Select desired medication. If not an IV or Liquid medicine, enter 0 in the amount field. Ensure all other information is correct (Date, Time, Route). Save work using appropriate tab. For Medications that have to be double signed (ex. Heparin or Insulin), document the name of the Nurse who also signed in the Comments Field. The Filters at the top can filter by Time/Route, Drug Name, or Type.

To verify that Medications have been charted, go to the Intake Screen. The Medication entered from the Pharmacy/RN Task should be listed. If it is not on the Intake Screen, enter per Intake Instructions. Discontinued medications will be highlighted in Orange at the bottom of the screen.



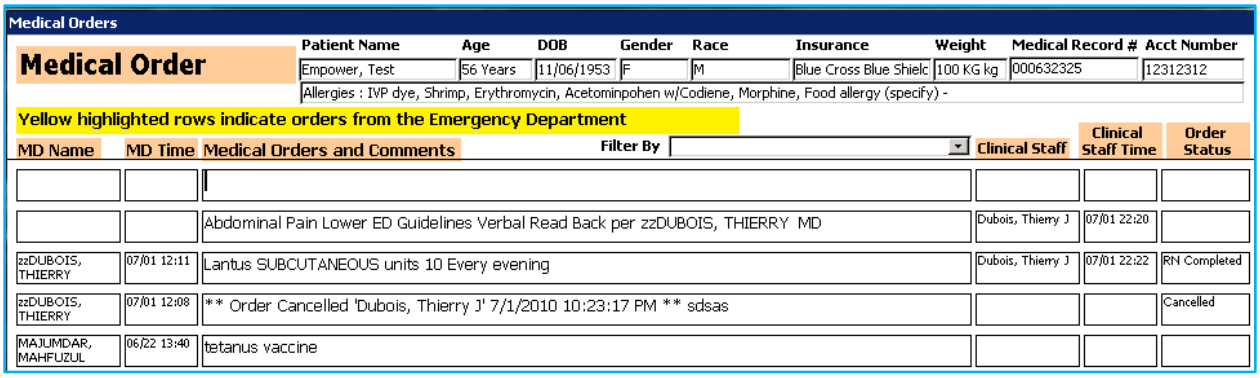
Clinical Notes

Nurses Notes: In this area, Nurses and Medical Assistants will document their own assessments and observations. Single click on the 1st row to open a large pop-up form with several options for documenting. On the right is large white box where the user can free-text any type of note. In the upper left corner is a drop-down table. Templates and phrases can be selected from the drop-down and they flow to the white box on the right. It is possible to use a combination of drop-down phrases and free-text.

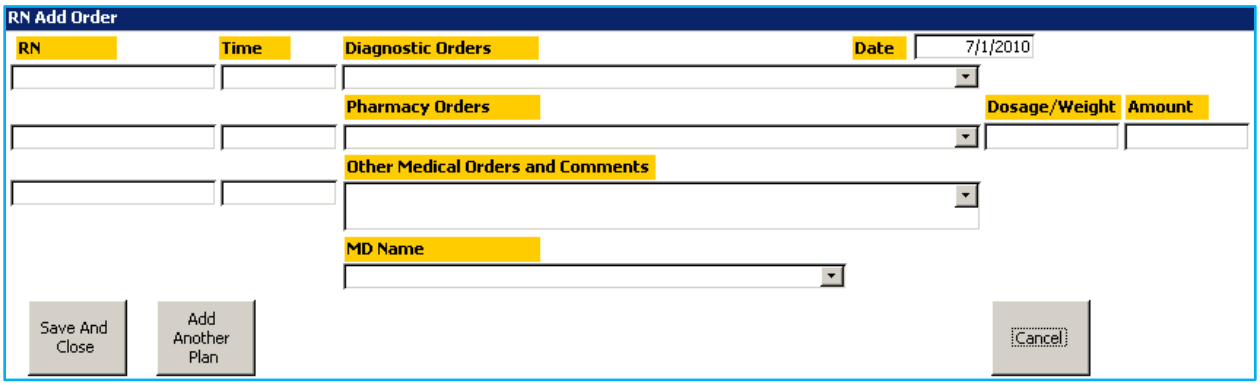


Medical Orders

Medical Orders are those interventions that make the patient feel better. This is an interactive screen, which allows nursing to enter any Intervention or any Diagnostic Test. To sign medical orders, single click on Clinical Staff or Clinical Staff Time. A new pop-up window will open up and the option to sign on one order or all orders is available. (The time can be modified if needed) In the Order Status area, a new window will pop up to document completion, refusal, or cancellation.



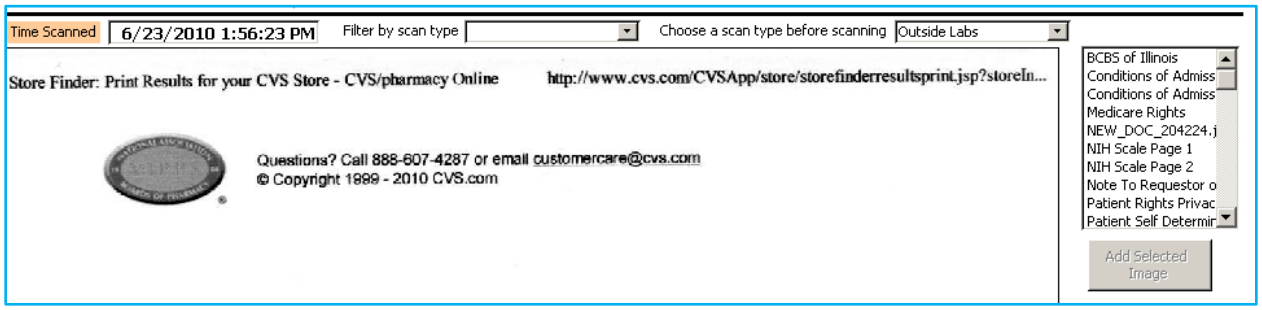
Entering Medical Orders: Click in the white box to open a pop-up form for entering orders. The user can enter orders by clicking the box and using the drop-down menu or free text. The Diagnostic Order drop-down includes all of the commonly ordered radiology tests. Pharmacy Orders drop-down includes common medication. Other Medical Orders and Comments drop-down is an area for orders not previously used or free text. It is necessary to choose a practitioner to assign the order. If a diagnostic test is ordered by selecting from the lists in Medical Orders, it will flow to the Diagnostics Screen where the results will interface and populate the result fields.



Scan Documents

To scan or view scanned documents click ‘Scan Documents.’ To scan; place the document in the scanner, choose a scan type, and click ‘Scan.’ To view other scanned documents, the ‘Previous’ Button will scroll through individual scans or there is the ability to filter through the

drop-down menu. Documents can be viewed on any computer, but scanning can only be done at the computer directly connected to the scanner.



Patient List

This button will return the user to the Patient Roster.

Print

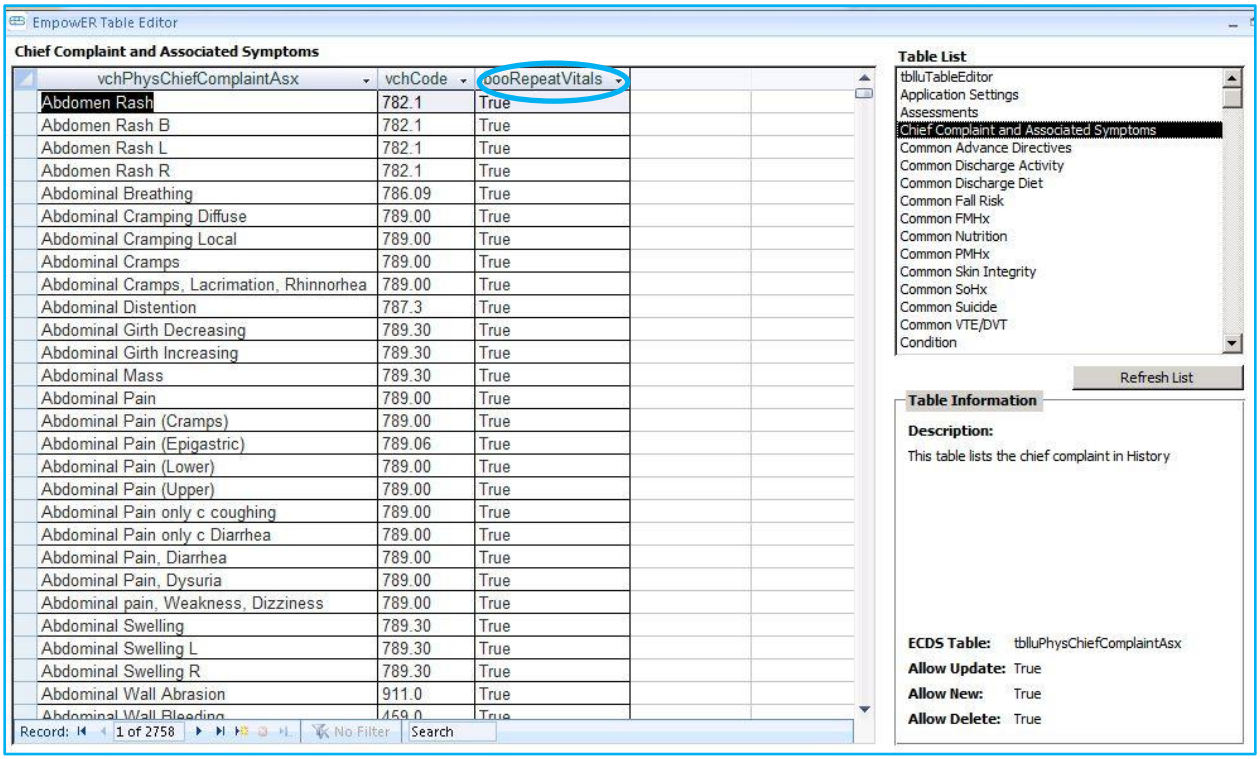
The Print button will open a window to give the different options to print. There is one Default printer assigned during set up, but there are other options if multiple printers have been installed. In addition, a dedicated prescription printer can be added.

Patient Reports

Information from visits and anticipatory guidance reports are generated from this button. Please see Chapter 9.

Vitals Reassessment

Empower has the ability to prompt the RN to obtain another set of Vital Signs with certain Chief Complaints. The Chief Complaints are chosen by the site administrator using the Table Editor. Choosing Chief Complaint and Associated Symptoms in the Table List or tblluPhysChiefComplaintAsx in Table Information displays the correct Table. Setting the column booRepeatVitals to True for the specific complaint will trigger the prompt.

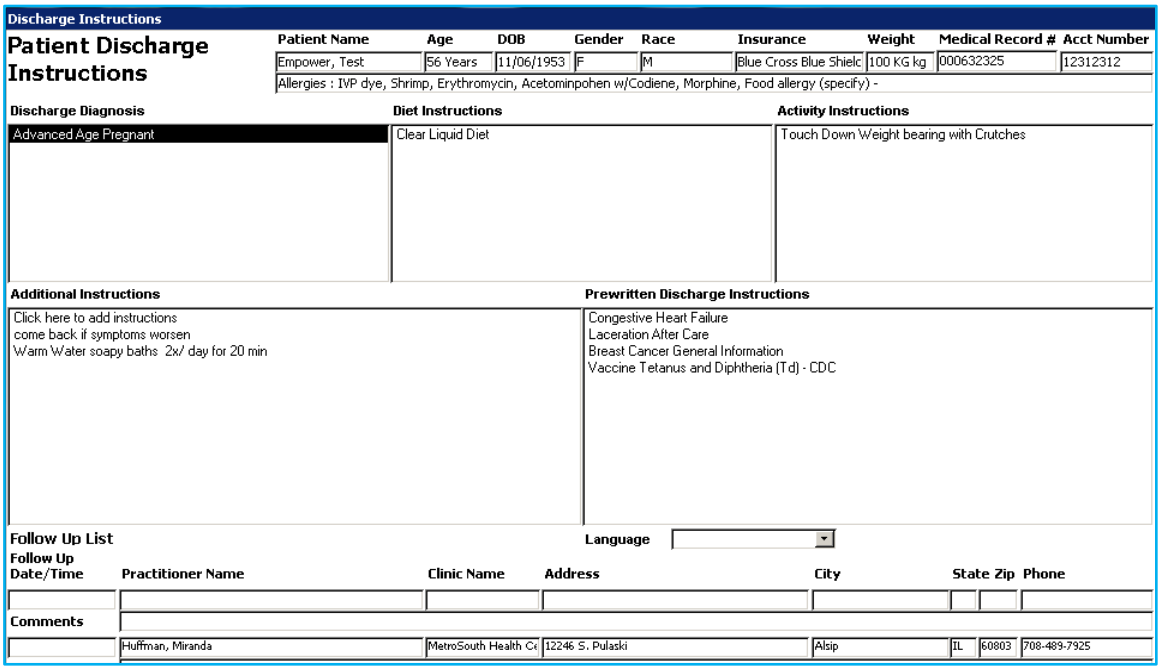


Upon **Print All** for that Chief Complaint, a message will appear to prompt for another set of Vital Signs.

Message
Missing Documentation
Message
Required
With the current Chief Complaint you are required to fill out a Full Set of vitals.
Nurses are required to perform a pain reassesment.
no RN Initials for the disposition.

MD Screens

This screen allows the user to view the practitioner's overview and review notes. These notes will be from the hospital, consultants, and the practitioner.



Discharge Instructions

In this area; practitioners, nurses, and medical assistants will select information to give to the patient as they leave the office.

Discharge Diagnosis: This is determined by the practitioner as is read only.

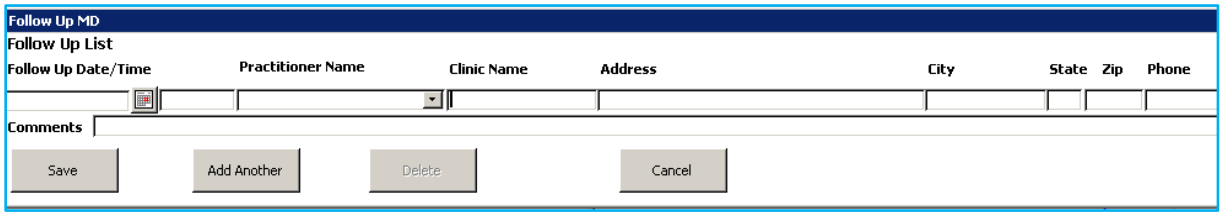
Diet Instructions: Double-click in the box to open up the options. Users can select from options or free text and save. Double-click on a selected item to delete or add text.

Activity Instructions: Double-click in the box to open up the options. Users can select from options or free text and save. Double-click on a selected item to delete or add text.

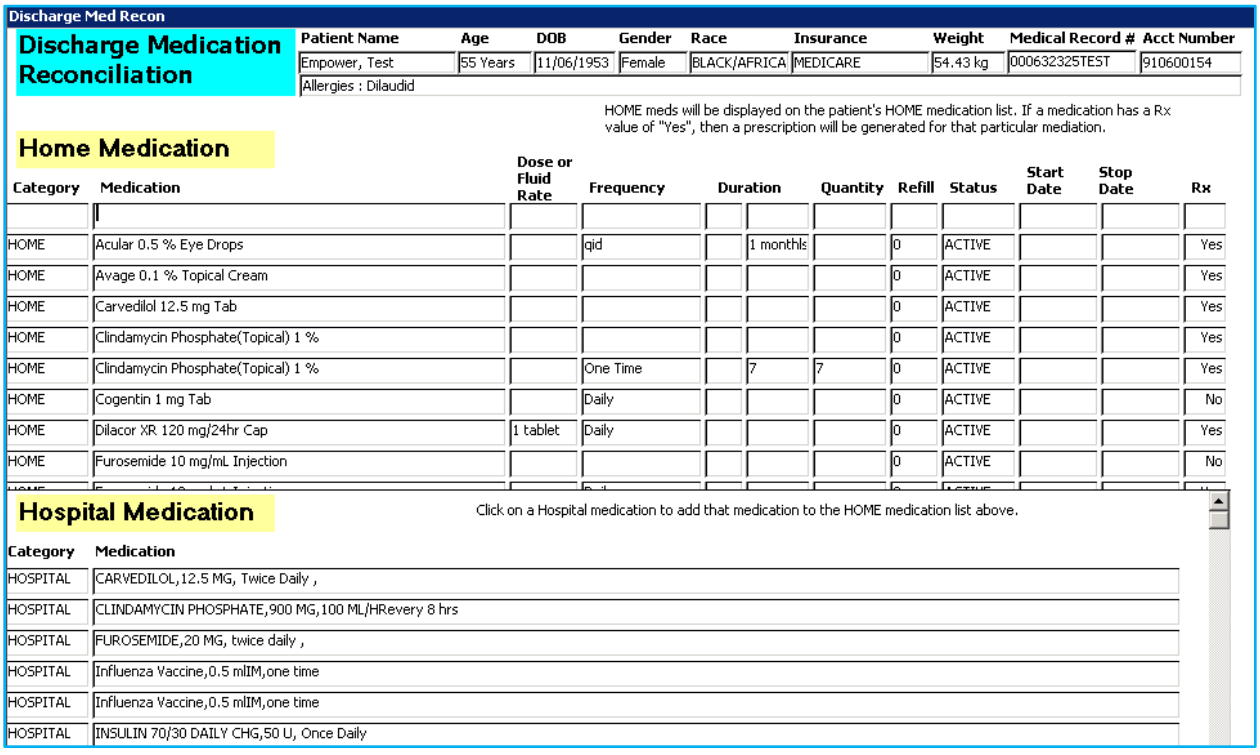
Prewritten Discharge Instructions: Double-click in the box to open up the options. Users can select from options by double-clicking from the list. If instructions are not in the list, use the drop-down box for other options. Once the proper instructions are found, use the 'Add to List' Button. Once all the instructions needed are selected, use the 'Save and Close' Button.

Language: This drop-down menu will select the language the instructions are printed out. English is the default.

Follow-Up List: In this area, follow up appointments and referrals to certain providers can be given to patients. Click on the first open the input box. Using the drop-down box, a pre-populated list of physicians with demographic information will fill the rest of the fields. Users can also free-text in any field if a practitioner is not in the list.



Discharge Rx: In the bottom right-hand corner is a button labeled 'Discharge Rx'. This will open the e-prescribing feature of Empower Inpatient+Ambulatory™. Practitioners will select which medication is to be prescribed. These medications populate the Selected Meds field. Use the drop-down menu Fax Locations to select the pharmacy. The 'Fax Meds' button will place the prescription in the Fax Queue. When finished, the 'Close' button will end e-prescribing. This is also the area that Medication Reconciliation will be completed.


Discharge Med Recon
Discharge Medication Reconciliation
Patient Name: Empower, Test
Age: 55 Years
DOB: 11/06/1953
Gender: Female
Race: BLACK/AFRICA
Insurance: MEDICARE
Weight: 54.43 kg
Medical Record #: 000632325TEST
Acct Number: 910600154
Allergies : Dilaudid
HOME meds will be displayed on the patient's HOME medication list. If a medication has a Rx value of "Yes", then a prescription will be generated for that particular mediation.
Home Medication
Category | Medication | Dose or Fluid Rate | Frequency | Duration | Quantity | Refill | Status | Start Date | Stop Date | Rx
HOME | Acular 0.5 % Eye Drops | | qid | 1 months | | 0 | ACTIVE | | | Yes
HOME | Avage 0.1 % Topical Cream | | | | | 0 | ACTIVE | | | Yes
HOME | Carvedilol 12.5 mg Tab | | | | | 0 | ACTIVE | | | Yes
HOME | Clindamycin Phosphate(Topical) 1 % | | | | | 0 | ACTIVE | | | Yes
HOME | Clindamycin Phosphate(Topical) 1 % | | One Time | 7 | 7 | 0 | ACTIVE | | | Yes
HOME | Cogentin 1 mg Tab | | Daily | | | 0 | ACTIVE | | | No
HOME | Dilacor XR 120 mg/24hr Cap | 1 tablet | Daily | | | 0 | ACTIVE | | | Yes
HOME | Furosemide 10 mg/mL Injection | | | | | 0 | ACTIVE | | | No
Hospital Medication
Click on a Hospital medication to add that medication to the HOME medication list above.
Category | Medication
HOSPITAL | CARVEDILOL,12.5 MG, Twice Daily ,
HOSPITAL | CLINDAMYCIN PHOSPHATE,900 MG,100 ML/HRevery 8 hrs
HOSPITAL | FUROSEMIDE,20 MG, twice daily ,
HOSPITAL | Influenza Vaccine,0.5 mlIM,one time
HOSPITAL | Influenza Vaccine,0.5 mlIM,one time
HOSPITAL | INSULIN 70/30 DAILY CHG,50 U, Once Daily

Print Orders

Click ‘Print Orders’ to print a hard copy of the Medical and Diagnostic orders for pharmacy, for the nurse to use when multiple orders need to be carried out and to verify patient identity at the bedside.

Tips

- Left-click on the Disposition field for a patient will bring up a red screen asking if you wish to remove the patient from the screen. You can click Yes/No. The patient record is always stored in Old Records.
- To switch between Empower and another program, open the other program first and then Empower. Use ALT/TAB to switch between the two programs.
- Throughout Empower Inpatient+Ambulatory™, there are message boxes and labels to instruct a user on how to use particular section or provide the correct documentation.
- To access a particular field and document information, simply left-click with the mouse.
- Review your entries and always click the Save button when it appears, as long as the correct information has been entered.
- Certain fields are required fields. The computer will prompt with a message box and by highlighting the required field in red if you have forgotten to enter required information.
- If you are uncertain of what to do or have selected the wrong patient, you can always click the 'Patient List' button to return to the Patient Roster.

Chapter 12: Provider User Manual

Introduction

The Empower Inpatient+Ambulatory™ computer documentation system was created by clinically experienced physicians and nurses. The program merges technological information with medical information to create a real-time documentation system that improves communication and enhances patient flow. EmpowerSystems™ has been recognized in the past as a success story and role model by the Joint Commission, and we continually monitor and adopt the changing Joint Commission standards in order to ensure continuing compliance. The system also ensures compliance by prompting the physician or nurse at various HCFA mandated junctions, electronically applying the physicians signature, and ensuring follow up by faxing the chart to the primary care provider or specialists office.

The program is dynamic and flexible, and can be customized to the needs of various physicians, nurses, and inpatient/ambulatory settings. Empower Inpatient+Ambulatory™ is also an inexpensive alternative to costly transcription or verbal documentation. This program, unlike others, is not template based, but rather is based on a single, free formed chart that is populated by the physician's or nurse's description of the patient's history, physical exam, diagnostic tests, medical orders, and clinical summary to provide an accurate EMR, or electronic medical record.

The Empower chart reflects the company's philosophy of 'One Patient, One Chart, One Database.' There is no need to collate several separate charts or pieces of charts into one record at the end of the patient encounter. Empower Inpatient+Ambulatory™ provides all the tools necessary in order to document the patient's clinical information while simultaneously caring for the patient. The software is written such that it follows the patient stepwise through the healthcare system, beginning with the registration process and ending with the discharge instructions.

Starting the Program

- Click on the Empower icon on the desktop.
- Log In is provided by your system administrator.
- Initial password is 'welcome'.
- When you log in with this password you will be prompted that your password has expired.
- Click 'yes' and enter your new password.
- Write down this log in and password.

Empower Inpatient™ and Empower ED™ Patient Roster

The following columns appear on the tracker, and can be modified as desired:

Acuity is based on the Emergency Severity Index (ESI) 5 level system. Empower also has customizable tables for hospitals that use a different system. The ESI 5 level is assigned in Triage:

ESI Level	CATEGORY	COLOR
1	Resuscitation	RED
2	Emergent	RED
3	Urgent	YELLOW
4	Not urgent	GREEN
5	Referred	GREEN

Patient Name appears on the tracker when entered by the ADT interface or the 'Add a Patient' button.

Age appears on the tracker when the date of birth is entered by the ADT interface or the 'Add a Patient' button.

Chief Complaint is initially populated with the complaint entered by the ADT. It is updated by the chief complaint from the Triage Clinical Note and finally replaced by the chief complaint on the physicians note.

MD Name identifies the doctor caring for the patient with the physicians initials.

RN Name identifies the primary nurse caring for the patient. By double clicking in this box, a pop up screen will appear with the list of nurses' names. Clicking on the appropriate name will set the corresponding initials to appear in the box. The initials will also populate any orders or notes entered. This field should be updated when the primary nurse is changed.

Disposition is entered by the doctor or nurse on the discharge screen and populated into this field.

Exam Room is populated with the room number from the triage clinical note unless another room number is entered by clicking on the box and selecting a room.

Bed Assignment provides an area to enter the inpatient room number where appropriate. It also functions as a "sticky note". By clicking on the box, a pop up field appears that allows 18 characters of free text. This note will appear on the tracker, and can be used for ISOL or other information.

Time in ER in hours and minutes. The box appears **Green** for patients who have been in the department for less than three hours, **Yellow** for patients who have been in the department for more than three but less than five hours, and **Red** for patients who have been in the department for more than five hours.

Diagnostic and Medical Orders section has five columns, each with one of the following designations:

- **U = Urine**
- **B = Blood**
- **E = EKG** and other diagnostics like Pulse Ox & Peak Flow.
- **R = Radiology**
- **M = Medical Interventions** like an IV or medication.

When orders are entered, an **Orange** box with the letter **N**, for New, is displayed in the box. When an order has been completed, the box turns **Purple** and displays the letter **E** to reflect that the order has been executed.

The **R, D, C, X, U** columns are interface columns that reflect the following:

- **R** = Registration, this box will display green when the full registration process is complete.
- **D** = Diagnostics, this box will display yellow when all diagnostic tests are complete.
- **C** = Critical Values, this box will display a red C to notify clinicians of critical/abnormal lab values.
- **X** = Radiology Results, box will display yellow when a radiologic study is completed and uploaded into the PACS system
- **U** = Unit Clerk, when the Unit Secretary signs off on orders that have been entered in the Core system (CPOE is not active) or, for those with direct order entry, checks to make sure that orders have crossed into the Core system.

Admit To displays the name of the doctor to whom the patient is admitted.

Chart Status appears red until the chart is complete. When the chart is ready for disposition, it appears green. When the ED physician finalizes the chart, the Empower ED™ risk management program scans the chart for incomplete documentation, and then guides the physician through the completion of all necessary documentation. Completing the documentation will change the status box color to green, and the word 'Ready' will appear within the box. The nurse can then print and close the chart, and is likewise prompted to complete any required documentation.

Filtering/Sorting the Tracker

Filters can be applied to limit the patients displayed by selecting from the drop-down fields 'Name Search', 'Location Search', 'MD Search', 'Disposition', or 'Exam Room'. To remove the filters, select 'All' from the drop-down fields. Sorting can be done on any column by right-clicking on the column heading and choosing a sort option

Empower Ambulatory™ Patient Roster

Patient Name appears on the tracker when generated by the ADT interface or by using 'Add a Patient.'

Age as entered when date of birth entered by the ADT interface or by using 'Add a Patient.'

Gender as entered by the ADT interface or by using 'Add a Patient.'

New/Established is populated by clicking on the box once.

Exam Room is populated by clicking in the box once.

Appointment Time/Appointment Status is entered by the ADT interface or by clicking in the box (Appointment Status only).

Time in Office is calculated in minutes from the time that the patient is placed on the Roster.

Complaint/Message is free-texted by clicking on the box.

MD Name uses a dropdown menu to identify the name of the doctor caring for the patient.

Disposition is entered by the doctor on their documentation screen and crosses over to the tracking board.

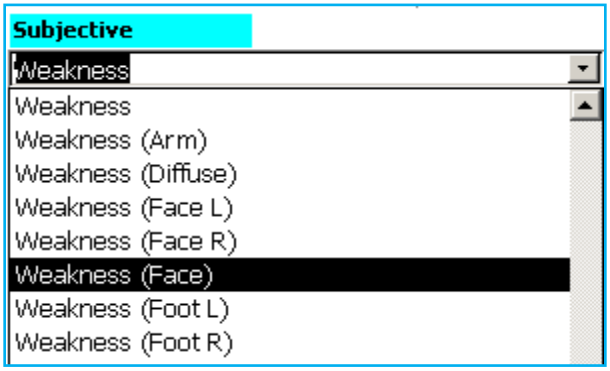
Orders displays an orange box with a letter **N** when new orders are entered. When the order has been completed, the box turns purple with a letter **E** to reflect that the order has been executed.

Open the Patient Chart

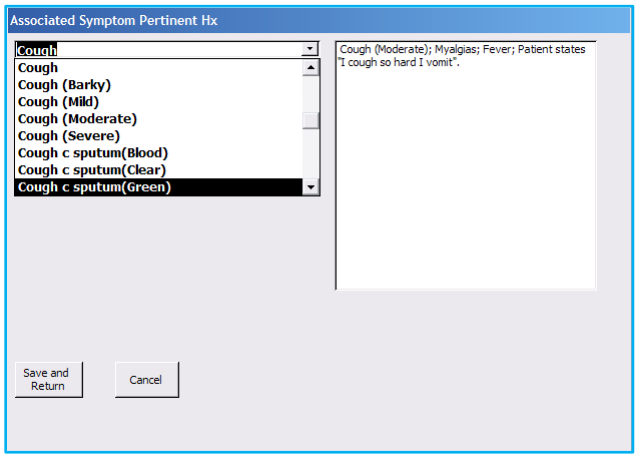
Clicking on a patients name open the patients chart and navigate to the opening screen, the subjective part of the patient encounter.

Data Entry and Navigation

Drop-Down Boxes: Clicking on the small arrow on the right side of the scroll box will open the drop-down menu. Typing the first few letters begins the auto-fill process and the list scrolls to area of the menu that most closely matches the typed entry**.**



Pop-Up Forms: If a white box with no arrow appears, click in the white space and a pop-up form appears. This provides a Drop-Down list and a blank area to free text.

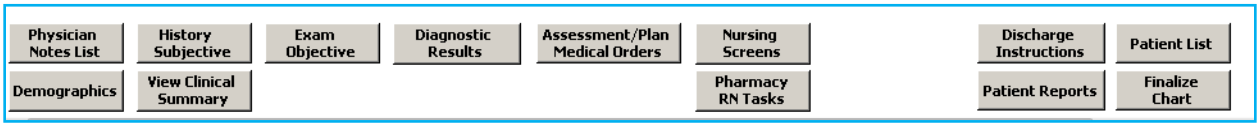


Check Boxes: These allow the user to click a small box to acknowledge a prewritten statement.

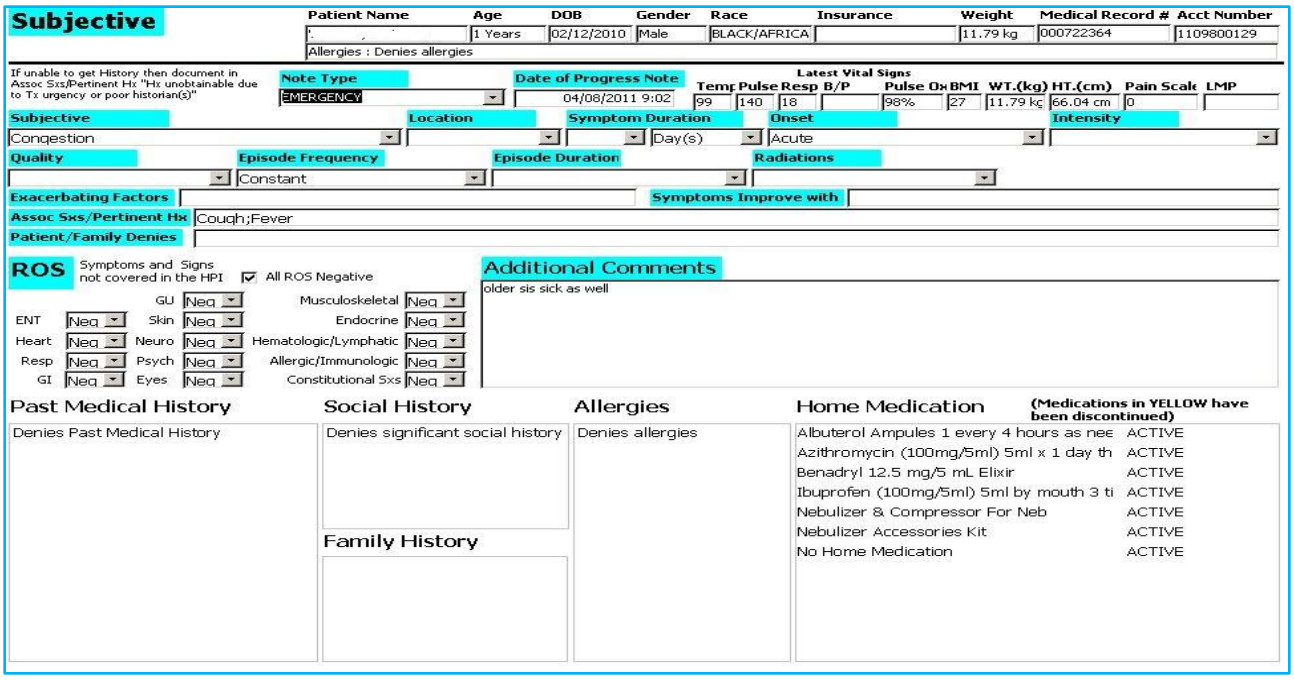
Tab and Enter Keys: Using 'Tab' or 'Enter' on the keyboard will move the cursor from one field to the next. Fields can also be navigated by left-clicking the mouse in the appropriate box.

Required Fields: Empower has certain required fields, and when a user attempts to close the chart, the computer will guide them with a message and red highlight to the required area of documentation.

Gray Control Buttons: At the bottom of each screen are grey buttons which serve to move through the various portions of the chart. The current screen is automatically saved when moving from one screen to the next.



Subjective



Subjective: This is the chief complaint and is a required field. It can be selected from the list for easier coding or manually entered. If uncertain of the chief complaint, select 'Waiting Evaluation' as a temporary complaint and return to the field at a later time. Also, in the interest of time, this can be entered and then the user can move on to Diagnostic and Medical Orders and return to complete the Subjective and Physical Exam when time permits. If a history is not attainable due to the patients' condition, select the phrase 'Hx unattainable due to Tx urgency or poor historian' in 'Assoc Sxs/Pertinent Hx'. This phrase will effect coding to a Level 5 in the ED without requiring the completion of all of the fields.

Review of Systems: These can be entered individually, or the 'All Systems Negative' box can be checked and then the individual positive items can be detailed separately. There is also a free text box for additional comments.

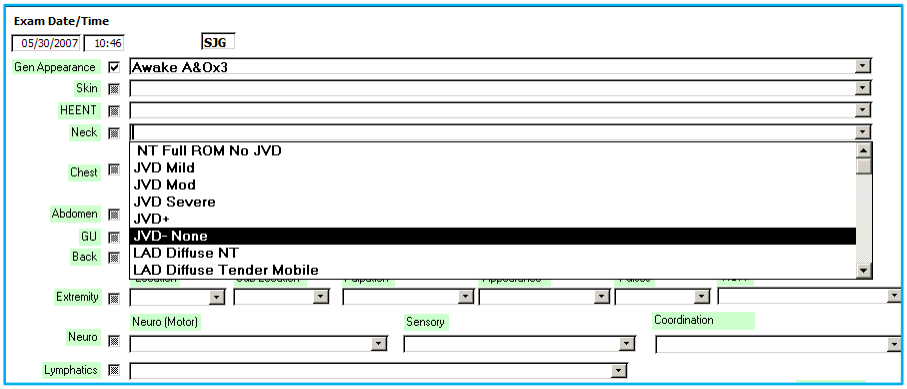
Additional Comments: This area can be used for more detailed histories or physician templates.

Past Medical History: This area auto-populates with the information obtained in the Admission/Assessment area. Additional information can be added by checking the appropriate boxes or clicking in the white box and free texting under 'Other PMHx.'

Social and Family History: Check appropriate boxes or click in the white boxes labeled 'Other' to add more information. Smoking status is required to meet Meaningful Use.

Physical Exam

To document the Physical Exam check the box on the left to populate a normal statement for that system. Clinking on the arrow to the right, or beginning to free text, causes drop-down tables appear. If an appropriate exam is not found in the drop down list, the physical findings can be free texted.



The 'Date/ Time' of the exam will default to the time of documentation. If this differs from the actual time of the exam, it can be entered if different by clicking in the time box and entering the time in military time with no punctuation, e.g. 2:00 PM is entered as 1400.

Repeat or Additional Notes

Check boxes are available for required EMTALA discharge statements, transfers, AMA and LWBS. Click in the white box to free-text a repeat exam or provide additional information regarding the physical exam. Phrases can also be selected from the drop-down box.

Laceration Procedures

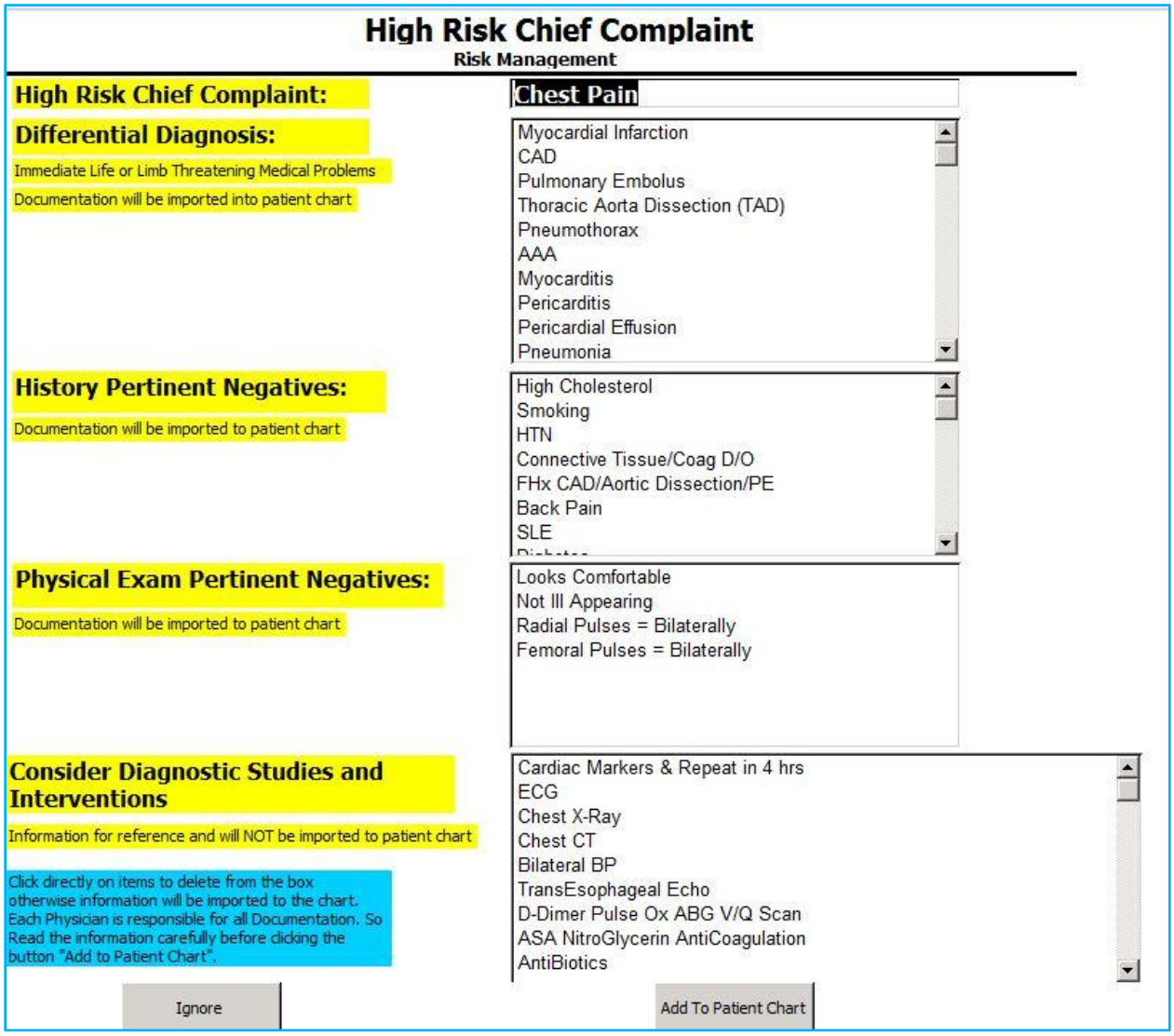
Laceration details such as location, length, shape, depth, wound exploration and procedure must be selected from the drop-down lists to provide the required documentation for appropriate reimbursement. The additional comments allows free texting of additional details.

Other Procedures

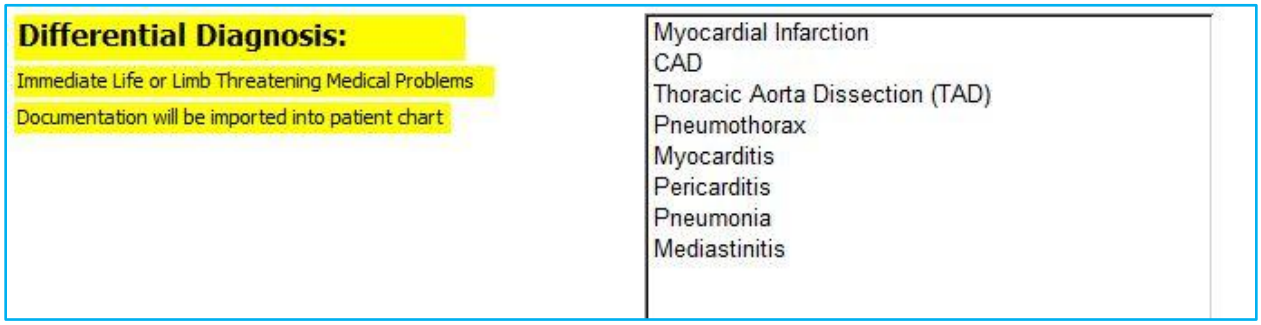
Procedures must be selected from the list, and free-text is not permitted due to coding regulations. Free texting may be done in the 'Additional Comments' section.

High Risk Chief Complaints

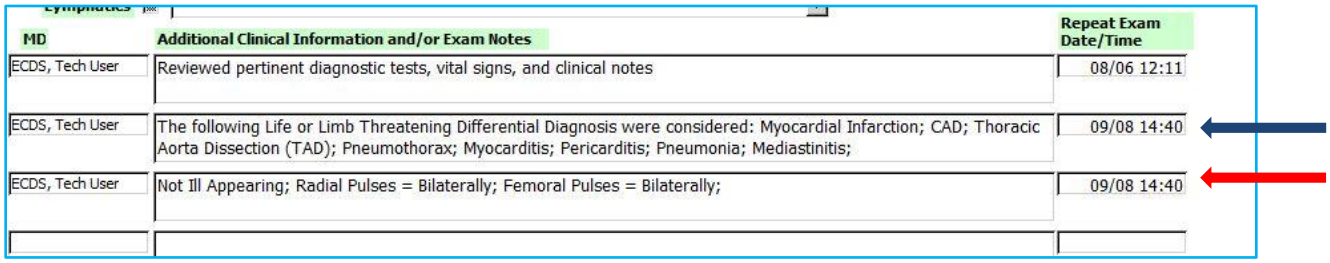
Empower can improve Clinical Documentation with certain Chief Complaints. These High Risk Chief Complaints are identified in the Subjective box of the History/Subjective portion of the Emergency Note. Once the Chief Complain is entered, a Pop-up window opens and the Practitioner is able to document statements to manage and decrease risk in the Emergency Note.



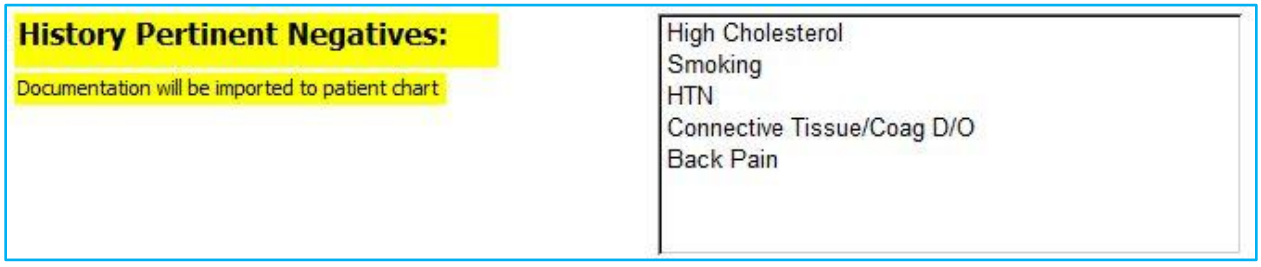
The First Section: Differential Diagnosis



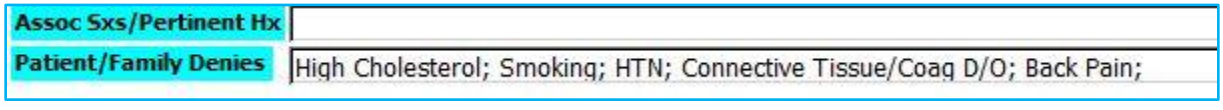
This area is the medical problems considered with the Chief Complaint. Clicking on one of the problems removes it from the list and, therefore, documentation. Please note the general pop-up screen-shot compared to the one above. Pulmonary Embolus, AAA, Myocarditis, and Pericardial Effusion have all been removed. The rest of the problems left populate to the Physical/Objective Section (Blue Arrow) Please Note, once removed these problems must be manually entered.


MD
Additional Clinical Information and/or Exam Notes
Repeat Exam Date/Time
ECDS, Tech User
Reviewed pertinent diagnostic tests, vital signs, and clinical notes
08/06 12:11
ECDS, Tech User
The following Life or Limb Threatening Differential Diagnosis were considered: Myocardial Infarction; CAD; Thoracic Aorta Dissection (TAD); Pneumothorax; Myocarditis; Pericarditis; Pneumonia; Mediastinitis;
09/08 14:40
ECDS, Tech User
Not Ill Appearing; Radial Pulses = Bilaterally; Femoral Pulses = Bilaterally;
09/08 14:40

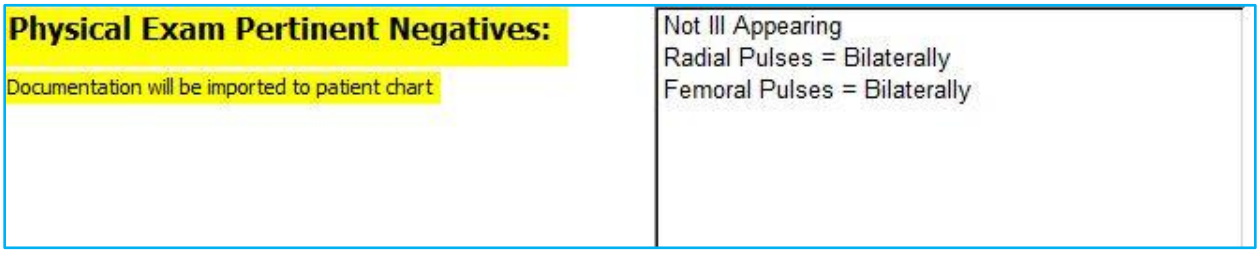
The Second Section: History of Pertinent Negatives



This area documents negative history of the patient. If the patient does have a history of these issues, clicking on that one will remove it from documentation in the History/Subjective Section in Patient/Family Denies. Please note Fx CAD/Aortic Dissection/PE, SLE, and Diabetes have been removed. Please Note, once removed this negative history must be manually entered.

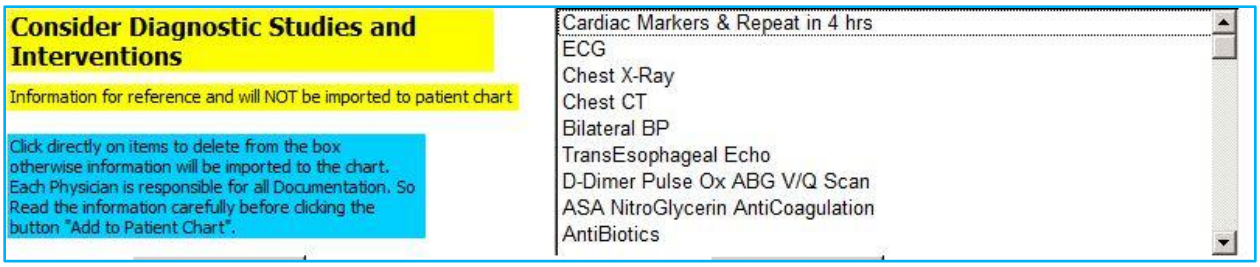


The Third Section: Physical Exam Pertinent Negatives


Physical Exam Pertinent Negatives:
Documentation will be imported to patient chart
Not Ill Appearing
Radial Pulses = Bilaterally
Femoral Pulses = Bilaterally

This area documents a Normal Physical Exam. If there are abnormalities that conflict with these statements, they should be removed. The history left will populate to the Physical/Objective Section (Red Arrow above). Please Note, once removed these history must be manually entered.

The Fourth Section: Consider Diagnostic Studies and Interventions


Consider Diagnostic Studies and Interventions
Information for reference and will NOT be imported to patient chart
Click directly on items to delete from the box otherwise information will be imported to the chart. Each Physician is responsible for all Documentation. So Read the information carefully before clicking the button "Add to Patient Chart".
Cardiac Markers & Repeat in 4 hrs
ECG
Chest X-Ray
Chest CT
Bilateral BP
TransEsophageal Echo
D-Dimer Pulse Ox ABG V/Q Scan
ASA NitroGlycerin AntiCoagulation
AntiBiotics

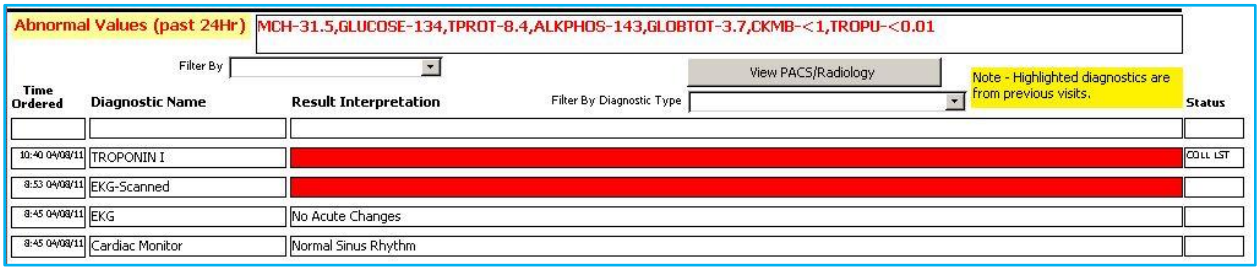
Unlike the other Sections, this is for display as is Read-Only. These orders will NOT be placed, nor will there be any documentation of these orders in the chart.

The bottom of the pop-up has two buttons.

Ignore will not import any documentation into the chart. Add To Patient Chart will import the Documentation to the areas specified above.

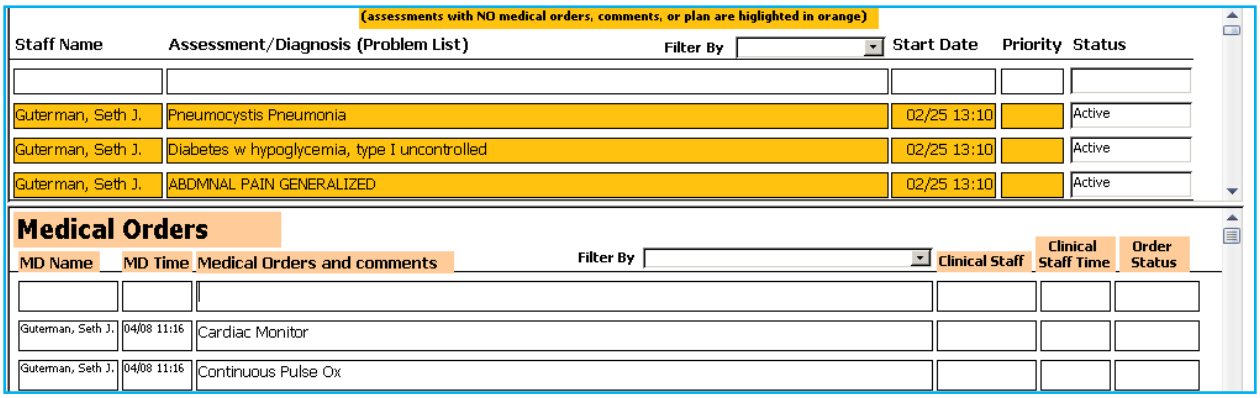
The High Risk Chief Complaints are editable. Edits can be made to age, gender, Chief Complaint, and any of the Sections. In addition, new High Risk Chief Complaints can be added. Please contact your Empower Support Personnel to learn more.

Diagnostic Results



- Abnormal Values will appear in red on the top of the screen.
- The interface will populate all laboratory results. If the laboratory result interface is not active, then the provider will need to interpret enter all results. For certain diagnostics such as the EKG or radiological studies, the provider will need to provide their own interpretation. Drop-down statements or free text may be used.
- To view results, click into Result Interpretation. Once in this screen, results can be trended.
- Clicking on any diagnostic or medical intervention (U B E R M) will navigate to the appropriate diagnostic or medical Intervention screen.

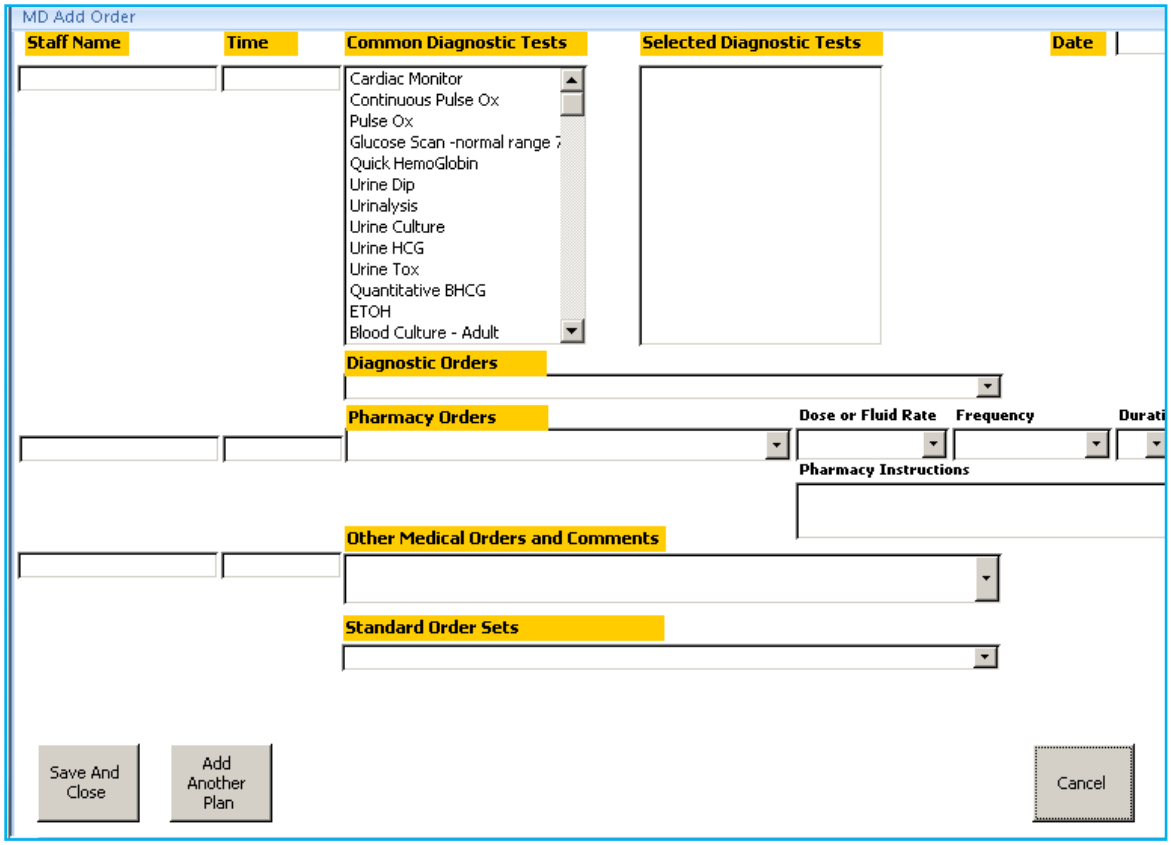
Assessment/Plan Medical Orders



- The initial Assessment/Diagnosis is taken from the initial Subjective complaint. It can be changed at any time, and additional Assessments can be added as needed.
- Each Assessment has a section for comments, start date, priority, and status.

Medical Orders

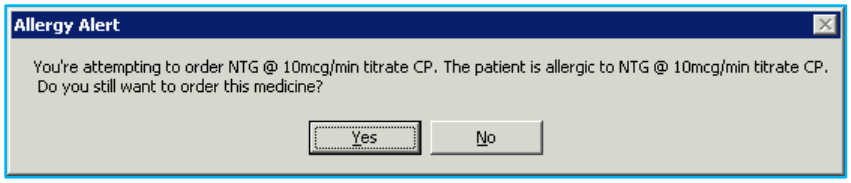
Click on the white box to open Medical Orders.



Common Diagnostic Tests: Orders are entered by clicking the appropriate box and then selecting from the drop-down menu. The menu can be customized to the institution. If the appropriate test is not found, then free texting can be used.

Diagnostic Order: This drop-down menu contains the most commonly ordered laboratory and radiology tests.

Pharmacy Orders: This drop-down menu contains the most commonly used medications. This field is locked to the Empower Smart Technology medication database to ensure that Drug-Drug Interactions and Potential Allergy Alerts are active.

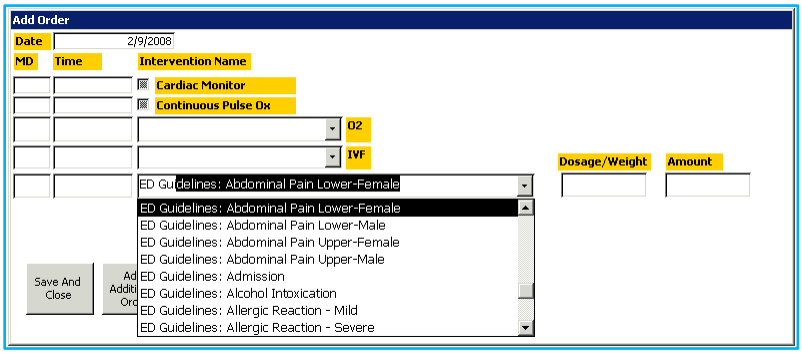

Allergy Alert
You're attempting to order NTG @ 10mcg/min titrate CP. The patient is allergic to NTG @ 10mcg/min titrate CP.
Do you still want to order this medicine?
Yes
No

When a weight-based medication dose is selected from the list, the dosage will be automatically calculated by Empower.

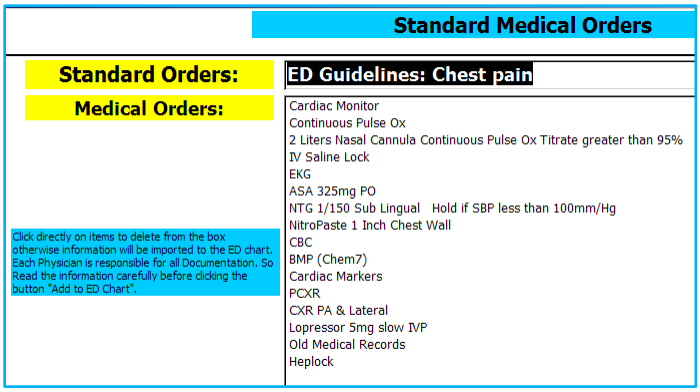
Other Medical Orders and Comments: This is an area for orders not found elsewhere. Orders can be free texted in this area. However, when orders are free texted, the results do not flow back to the diagnostics screen. It is recommended that free texting is avoided where possible as it can impact data capture and reporting. Contact your system administrator if any additions to the lists are required.

- **IVF:** This drop-down menu lists of all common IV therapies.
- **O2:** This drop-down menu includes all common methods of oxygen delivery.

Standard Order Sets: Open the 'Medical Orders' field by clicking on the white box. The standard order sets are in the bottom field. Clicking on this box opens a drop down menu that contains all of the order sets for the institution.



After selecting an order set it can be adjusted by clicking on items are not needed, and then selecting 'Add to Chart'.


Standard Medical Orders
Standard Orders:
Medical Orders:
ED Guidelines: Chest pain
Cardiac Monitor
Continuous Pulse Ox
2 Liters Nasal Cannula Continuous Pulse Ox Titrate greater than 95%
IV Saline Lock
EKG
ASA 325mg PO
NTG 1/150 Sub Lingual Hold if SBP less than 100mm/Hg
NitroPaste 1 Inch Chest Wall
CBC
BMP (Chem7)
Cardiac Markers
PCXR
CXR PA & Lateral
Lopressor 5mg slow IVP
Old Medical Records
Heplock
Click directly on items to delete from the box otherwise information will be imported to the ED chart. Each Physician is responsible for all Documentation. So Read the information carefully before clicking the button "Add to ED Chart".

Admitting Orders: (Optional) If the Emergency Department physicians write the admitting orders, then this feature can be used. It functions the same as Medical Orders when selecting Standard Order Sets

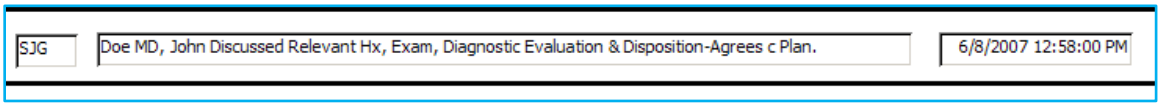
If additional orders are needed, then click 'Add Another Plan' and add any other necessary orders or order sets. When all desired Diagnostic and Medical Orders have been added, click 'Save and Close'. If the hospital does not have an order interface, the designated staff will then enter those diagnostics into the core system.

Disposition

This is found on the Assessment/Plan Medical Orders screen at the bottom. Disposition and Condition must be selected from the drop-down box. For admissions, enter the name of the admitting physician, which can be selected from the list.

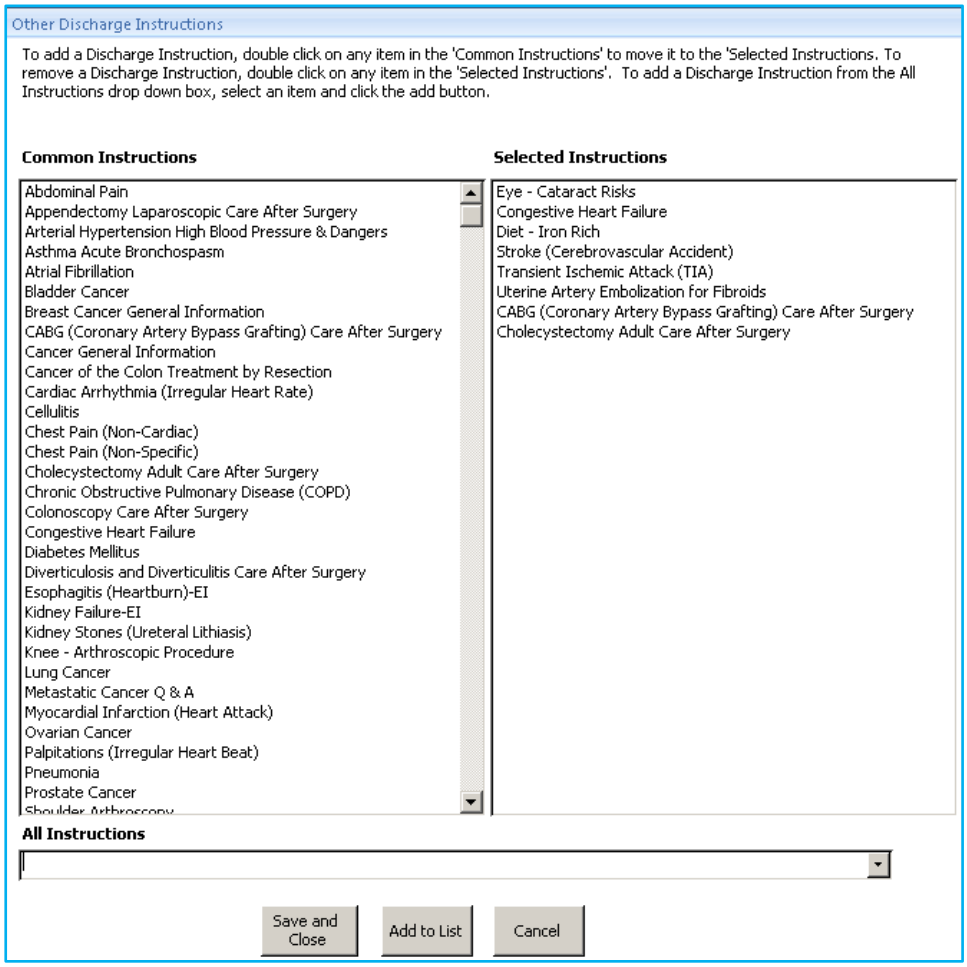
Notifications

This is also found on the Assessment/Plan Medical Orders screen. Click the gray button to bring up the Notifications screen and select a doctor from the list or free text the name of the admitting physician. This will auto-populate a statement regarding the notification of admission, discharge, or referral.



Discharge Instructions

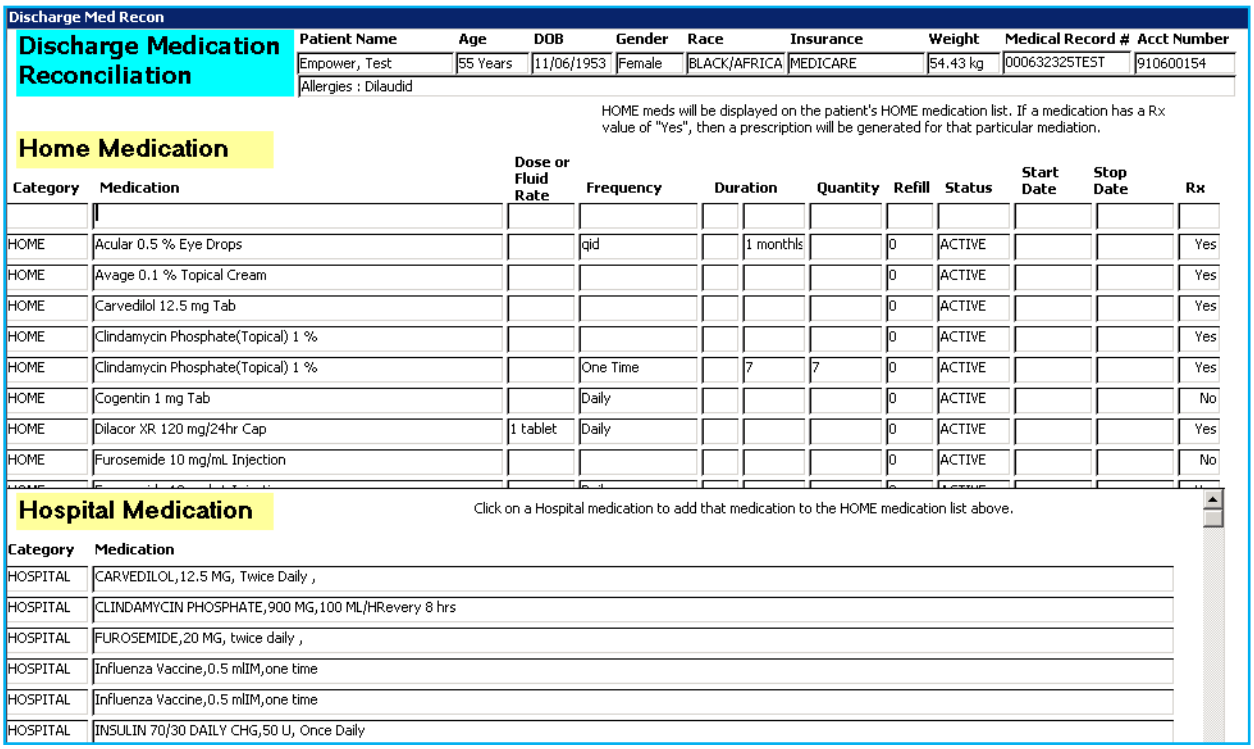
- Discharge Instructions can be accessed from any screen. The practitioner is required to select an Assessment/Diagnosis. The initial Subjective complaint appears as the initial diagnosis, but the physician must then choose a diagnosis that reflects the results of the diagnostics.
- The follow-up physician can be selected from the list, or alternatively, the Add/Edit can be used to enter a physician that is not on the list.
- Additional instructions can be added by clicking in the white box. They can be selected from the drop-down menu or manually entered.
- Empower offers pre-printed, instruction sheets for most common diagnoses using a quick pick list or a drop-down menu that has several thousand options. Double-clicking on the desired instructions moves the topic to the box on the opposite side. After all of the appropriate instructions have been selected, click 'Save and Close'.
- ExitCare™ discharge instruction content (English & Spanish) is integrated within this view. Additional ExitCare™ languages are available, at an annual fee based on hospital volume.


Other Discharge Instructions
To add a Discharge Instruction, double click on any item in the 'Common Instructions' to move it to the 'Selected Instructions. To remove a Discharge Instruction, double click on any item in the 'Selected Instructions'. To add a Discharge Instruction from the All Instructions drop down box, select an item and click the add button.
Common Instructions
Selected Instructions
Abdominal Pain
Appendectomy Laparoscopic Care After Surgery
Arterial Hypertension High Blood Pressure & Dangers
Asthma Acute Bronchospasm
Atrial Fibrillation
Bladder Cancer
Breast Cancer General Information
CABG (Coronary Artery Bypass Grafting) Care After Surgery
Cancer General Information
Cancer of the Colon Treatment by Resection
Cardiac Arrhythmia (Irregular Heart Rate)
Cellulitis
Chest Pain (Non-Cardiac)
Chest Pain (Non-Specific)
Cholecystectomy Adult Care After Surgery
Chronic Obstructive Pulmonary Disease (COPD)
Colonoscopy Care After Surgery
Congestive Heart Failure
Diabetes Mellitus
Diverticulosis and Diverticulitis Care After Surgery
Esophagitis (Heartburn)-EI
Kidney Failure-EI
Kidney Stones (Ureteral Lithiasis)
Knee - Arthroscopic Procedure
Lung Cancer
Metastatic Cancer Q & A
Myocardial Infarction (Heart Attack)
Ovarian Cancer
Palpitations (Irregular Heart Beat)
Pneumonia
Prostate Cancer
Eye - Cataract Risks
Congestive Heart Failure
Diet - Iron Rich
Stroke (Cerebrovascular Accident)
Transient Ischemic Attack (TIA)
Uterine Artery Embolization for Fibroids
CABG (Coronary Artery Bypass Grafting) Care After Surgery
Cholecystectomy Adult Care After Surgery
All Instructions
Save and Close
Add to List
Cancel

Prescription Writer

Click the gray box for Discharge Rx, which brings up the Prescription Writer screen. It also includes the Drug-to-Drug Interaction Alert and the Potential Allergy Alert. Select a prescription from the list.

The prescription writer can also be used to document work or school releases. The prescription writer is the ideal software to function in this dual manner because it automatically lists the name of the patient and the date that the medical care was provided, along with the physician's signature. Typical statements for a work or school release can be added using the Table Editor.



Discharge Med Recon

Discharge Medication Reconciliation

Patient Name	Age	DOB	Gender	Race	Insurance	Weight	Medical Record #	Acct Number
Empower, Test	55 Years	11/06/1953	Female	BLACK/AFRICA	MEDICARE	54.43 kg	000632325TEST	910600154

Allergies : Dilaudid

HOME meds will be displayed on the patient's HOME medication list. If a medication has a Rx value of "Yes", then a prescription will be generated for that particular mediation.

Home Medication

Category	Medication	Dose or Fluid Rate	Frequency	Duration		Quantity	Refill	Status	Start Date	Stop Date	Rx
HOME	Acular 0.5 % Eye Drops		qid		1 months		0	ACTIVE			Yes
HOME	Avage 0.1 % Topical Cream						0	ACTIVE			Yes
HOME	Carvedilol 12.5 mg Tab						0	ACTIVE			Yes
HOME	Clindamycin Phosphate(Topical) 1 %						0	ACTIVE			Yes
HOME	Clindamycin Phosphate(Topical) 1 %		One Time		7	7	0	ACTIVE			Yes
HOME	Cogentin 1 mg Tab		Daily				0	ACTIVE			No
HOME	Dilacor XR 120 mg/24hr Cap	1 tablet	Daily				0	ACTIVE			Yes
HOME	Furosemide 10 mg/mL Injection						0	ACTIVE			No

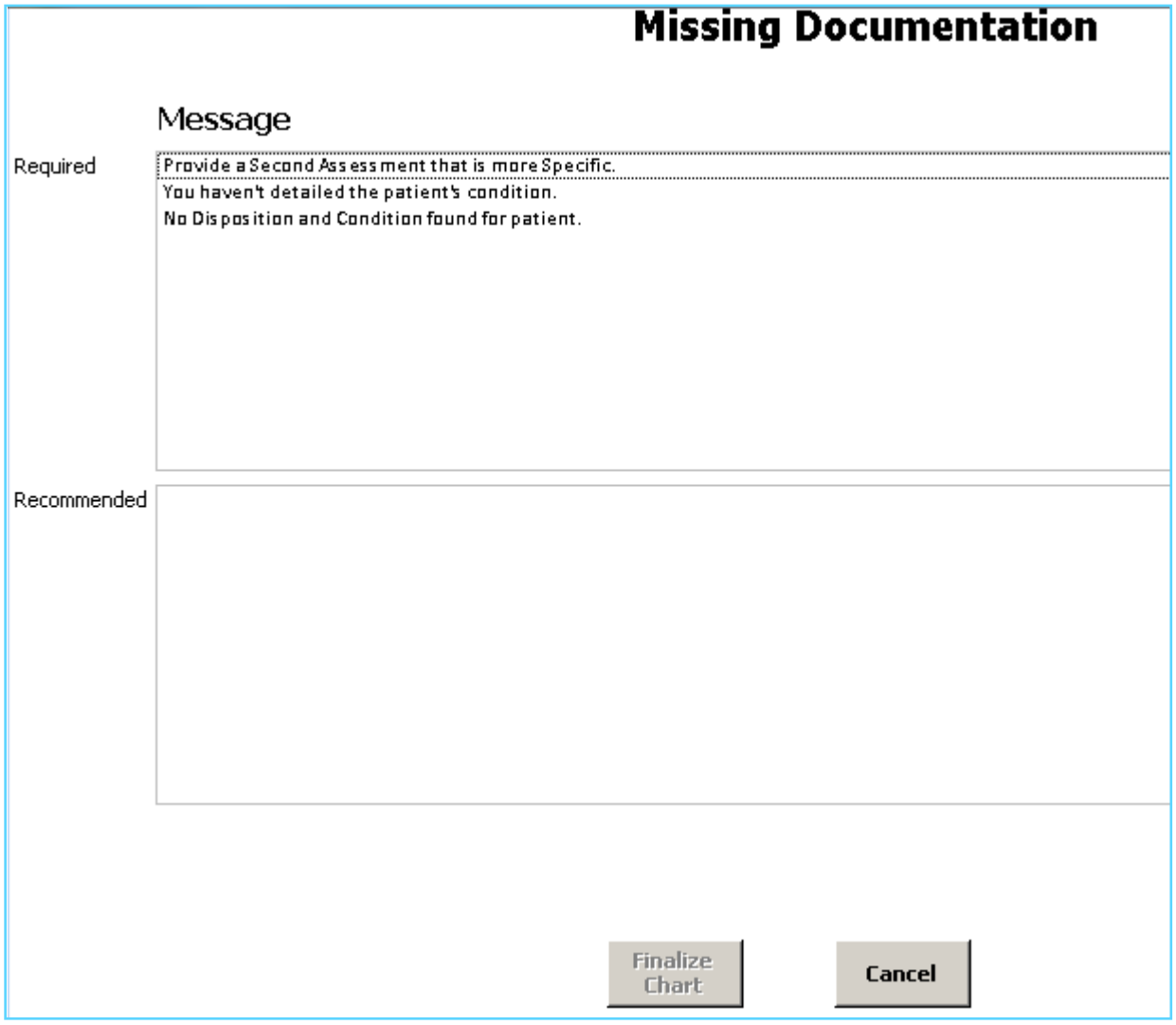
Hospital Medication

Click on a Hospital medication to add that medication to the HOME medication list above.

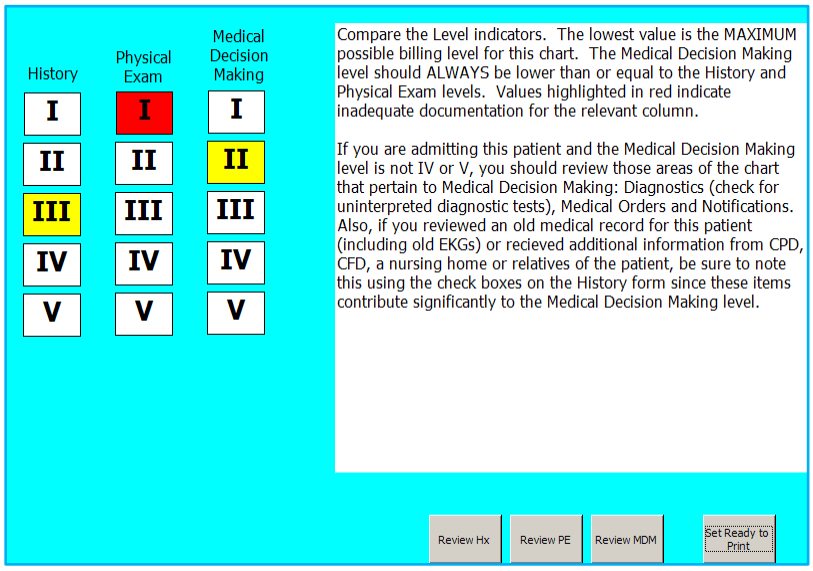
Category	Medication
HOSPITAL	CARVEDILOL,12.5 MG, Twice Daily ,
HOSPITAL	CLINDAMYCIN PHOSPHATE,900 MG,100 ML/HRevery 8 hrs
HOSPITAL	FUROSEMIDE,20 MG, twice daily ,
HOSPITAL	Influenza Vaccine,0.5 mlIM,one time
HOSPITAL	Influenza Vaccine,0.5 mlIM,one time
HOSPITAL	INSULIN 70/30 DAILY CHG,50 U, Once Daily

Ready to Print

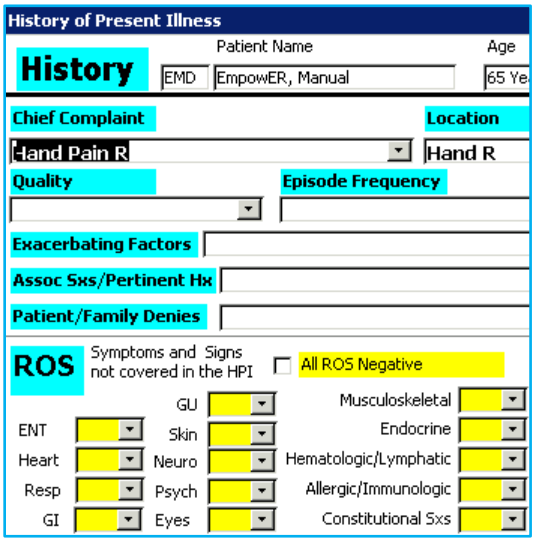
When the visit is complete, the provider can complete the chart by clinking 'Finalize Chart.' Clicking this button will initiate Empower's Smart Technology and will prompt the user for any missing documentation. When this is complete, it will be illustrated on the tracker that the chart has been closed. The nurse then completes the printing process.



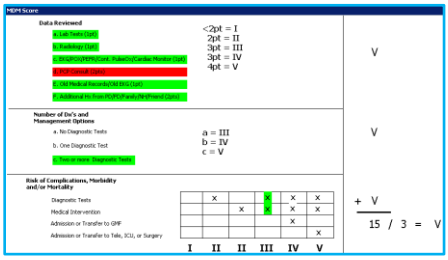
Complete the information required and click 'Finalize' again. Continue this process until you reach the following screen.


History
Physical Exam
Medical Decision Making
I
II
III
IV
V
Compare the Level indicators. The lowest value is the MAXIMUM possible billing level for this chart. The Medical Decision Making level should ALWAYS be lower than or equal to the History and Physical Exam levels. Values highlighted in red indicate inadequate documentation for the relevant column.
If you are admitting this patient and the Medical Decision Making level is not IV or V, you should review those areas of the chart that pertain to Medical Decision Making: Diagnostics (check for uninterpreted diagnostic tests), Medical Orders and Notifications. Also, if you reviewed an old medical record for this patient (including old EKGs) or recieved additional information from CPD, CFD, a nursing home or relatives of the patient, be sure to note this using the check boxes on the History form since these items contribute significantly to the Medical Decision Making level.
Review Hx
Review PE
Review MDM
Set Ready to Print

This screen allows you to return to HPI or Physical Exam and will highlight identified deficiencies.



Choose ‘Review MDM’ if you are interested in the systems calculation for MDM.



Once you have successfully set the chart ‘Ready to Print’ nursing will see the Chart Status on the Tracker and disposition the patient.

Congratulations! You have now completed the Empower chart.

Chapter 13: Interfaces

Empower interfaces to the hospital's core HIS using an HL7 engine or Scripting interface. The HL7 interface has been the most reliable and least expensive to maintain, and the Empower HL7 interface engine can be modified to any specifications set forth by the hospital. Empower can also build interfaces through other methods such as Scripting.

The following interfaces are included with the purchase of the Empower system.

- Registration (ADT)
- Diagnostic Results
- CPOE (Computer Physician Order Entry)
- Empower PDF Chart Export
- Charge capture

The charge capture interface is usually not executed until a thorough chart review process has been completed in order to identify any gaps in the documentation. This is because the charges are identified by the documentation of items and procedures using the Empower lookup tables, and if documentation of these items in the tables is poor, then the cost/benefit ratio of the automated charge capture may be determined by the hospital to be too low to justify its use. Empower requires that the Registration, Diagnostic Results, and Order Entry interfaces to be built prior to Go Live.

Registration (ADT)

There are three options for the registration interface, each of which has a different impact on the registration and triage workflow. Registration Interface design and workflow options are listed below in order of recommendation:

1. A short registration is completed in the hospital registration software, which creates an Empower chart through the interface, which is then followed up with full registration.

2. All patients are registered with a short form in Empower and the interface passes that information to the hospital registration software and assigns an account number.

3. Patients are registered separately in Empower and hospital registration software. Empower provides a unique patient identifier. The Registration Clerks then enters that unique patient identifier in a designated field on the patient chart which allows the interface to synchronize the Empower patient record with the hospital registration software. This is not recommended due to the high failure rates and other issues that can occur when information is manually entered.

The Empower Implementation team will discuss these options with the hospital team in order to assist in determining which registration interface is best.

Diagnostic Results

Empower is a clinical documentation tool intended to replace the clinician's pen and paper, and not the official laboratory record. The hospital is to provide the laboratory dictionary (mnemonics, codes, messages, etc.) from the Health Information System which is then mapped by Empower.

Empower, working as the clinician's pen, affords the clinical administrator the discretion to identify which tests or components are clinically significant and are to be included as part of the Empower order process. Empower references the provided Abnormal/Critical flags from the host interface so that any site-specific variations will be identified and highlighted. Each individual physician should still look at each laboratory value rather than rely exclusively on the systems prompts.

Order Entry (CPOE/Automated Unit Secretary)

The Empower order entry interface is designed so that instead of the unit secretary manually ordering diagnostic tests from the hospital menus, Empower electronically orders the same diagnostic tests. Unlike other systems that require specific ancillary questions to be answered prior to accepting an order, Empower provides 3 options for satisfying such requirements:

1. Empower can automatically answer "relevant" clinical information if the information is already documented in Empower, for example, whether the patient is pregnant or taking coumadin.
2. Empower can provide default responses to standard questions, for example, a question such as how the patient is transported may always be answered as portable.
3. The clinician and manually enter the answers to the questions.

Diagnostic Results & Order Entry Testing

Empower has successfully implemented a multitude of interfaces with numerous systems. Experienced Empower clinicians reference the dictionaries provided and match them with the tables in Empower to complete the mapping process. The hospital team will also be provided with a spreadsheet of this mapping to review. This will not only reduce any translation errors but also expedite the testing process. Even with this process, however, there is always the chance that there may still be unintentional errors created in the interfaces between the clinicians' language and the hospital dictionaries. Empower policies, which should be

implemented at the interface Go Live, assist in identifying any errors that may occur when linking the names for specific diagnostic orders and results in Empower with the analogous names in the hospital dictionary. The hospital should implement these policies and procedures in order to prevent any delays or miscommunication that might occur in the early phases of the interfaces development and deployment.

The following appendixes are provided to identify and communicate any problems with the interfaces during and after the Go Live:

Appendix 13A: Workflow Procedure for CPOE Interface – Post Go-Live

Appendix 13B: Hospital Order Entry Problem Log Sheet

Appendix 13C: Diagnostic Results Interface Workflow - Post-Go Live

Appendix 13D: Hospital Diagnostic Results Problem Log

Empower PDF Chart Export

As mentioned in Chapter 8, the Empower final chart is formatted in an Adobe PDF file. This file is generated from the Empower App Server and stored on the network drive provided. The file is then available for the hospital to import to their document management system. This task may be contracted with Empower, please refer to the signed contract for clarification.

Empower HL7 Orders and Results Interface Specifications

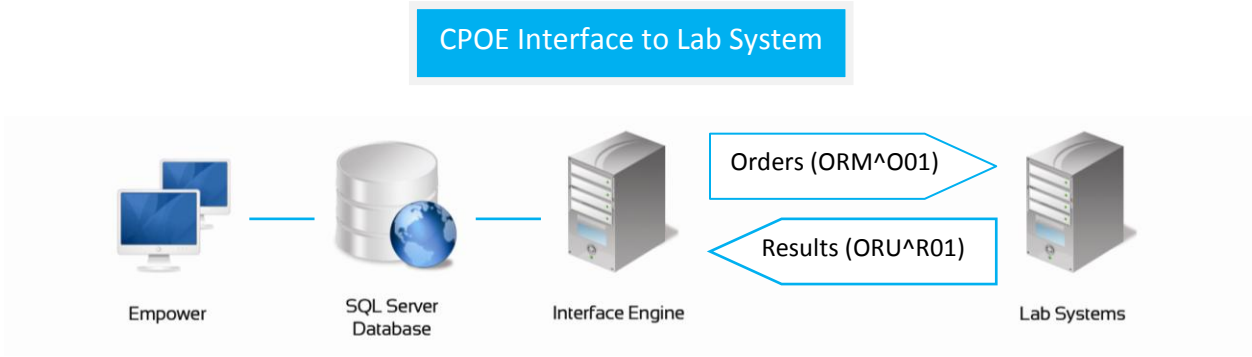
Subject to change during development

Order/Result Processing

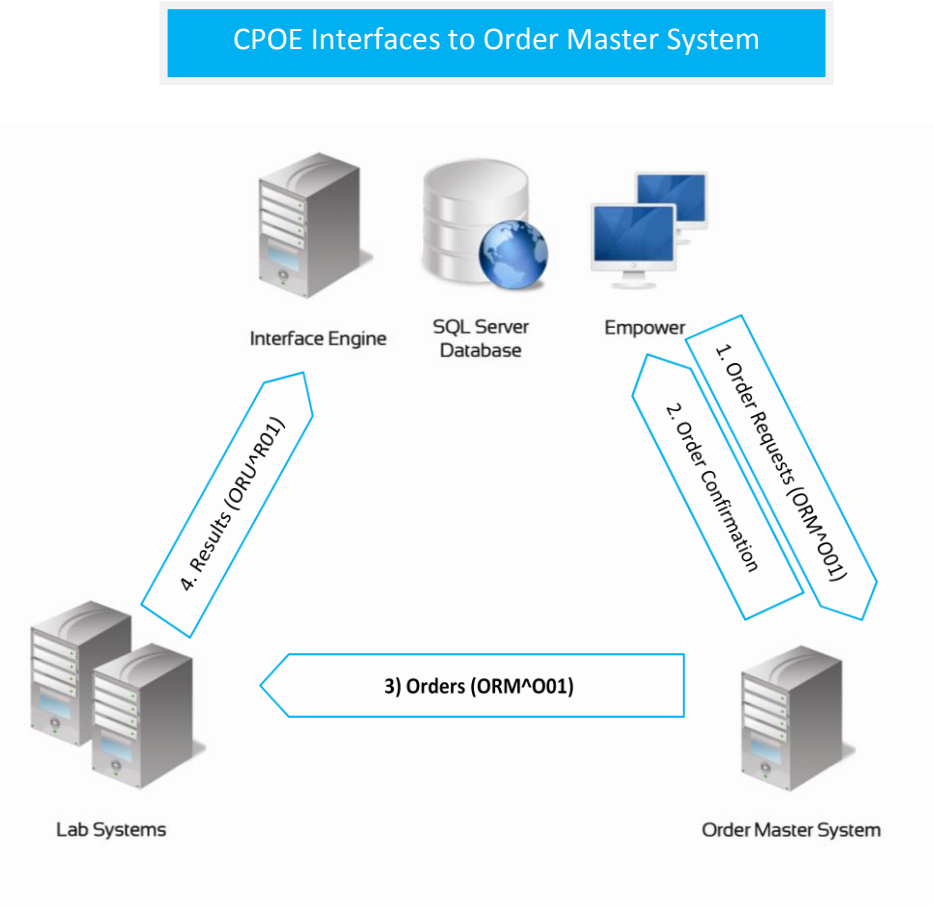
Understanding order and result identification and the stages of the order life cycle is crucial to ensure the proper implementation of the orders and results interfaces.

Orders in Empower are identified by the order number. The outbound interface identifies the order with a "placer order number" that can be generated at the time a new order is created by the outbound interface. Ancillary systems use their own schemes to generate "filler numbers" which are sent to the inbound Results interface. Both of these numbers are associated through a translation table to the Empower order number. The Orders interface is able to send both full orders (with order placer number) and order requests (without the placer number).

In the case of an interface to a single lab system, full orders will be sent out with a generated placer number, and results from the lab system will be processed.



When interfacing to an Order Master System which handles the generation of order numbers for multiple lab systems, Empower will send out order requests without a placer number. The Order Master System will then send back an Order Confirmation message with the generated order number, and forward the original order to the appropriate system. The Lab System will then send the results directly to Empower which will be associated with the order number received by the Order Confirmation message.



Order Identification

The value of the ancillary systems "filler number" is determined entirely by the ancillary system. The value of the "placer number" can be generated by one of the following strategies.

Standard Foreign Order Number Strategy (Default)

This strategy sets the Empower "placer number" to the same value as the ID of the record in the Empower database table.

i.e. 12345

System Specific Foreign Order Number Strategy

This strategy sets the Empower "placer number" to "EMPOWER-" plus the value of the ID of the record in the Empower database table.

i.e. EMPOWER-12345

Creation of New Order by Empower

The Empower "placer number" is created for the new order. The ancillary system should fill in this placer number in the placer field for all subsequent messages about this order.

Order Status Change

Status changes are usually only sent by the ancillary system. These should be sent with an order control code of SC. Currently the inbound interface supports transitions to in-progress and completed.

Order Cancellation

Cancellations are a special kind of status change. They should be sent as an order message with a CA order control code.

Outbound Orders

The Outbound Orders interface will send HL7 2.2.
The Outbound Orders interface will send the following message trigger events.

Trigger Events

O01 General Order Message

Supported Order Control Codes

NW	New Order
NA	Number Assign
CA	Cancel Order Request
SC	Status Changed

Although the Outbound Orders interface is HL7 2.2 compliant, some segments and fields will not be used for this interface implementation. Listed below are the various triggering events and segments that include data that will be sent from Empower. This subset of HL7 segments is offered only to show which segments are important for this implementation.

Message Definitions

	General Order Message	
O01	MSH	Message Header
	PID	Patient Identification
	PV1	Patient Visit
	AL1	Allergy Information
	ORC	Common Order
	OBR	Observation Request Segment
	OBX	Observation/Result

Inbound Results

The Inbound Results interface will receive HL7 2.2 or 2.3 ORU messages from the Interface Engine and will store clinical data necessary to perform the Results Viewing functions of Empower.

The Inbound Results interface will accept the following message trigger events.

Trigger Events

R01 Unsolicited Transmission of an Observation

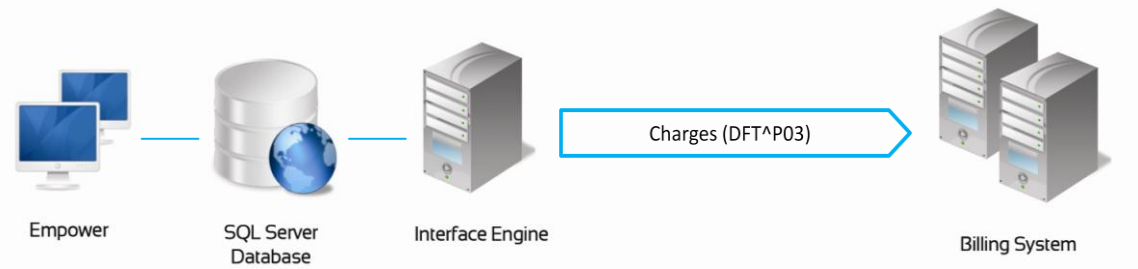
Although the Inbound Results interface is HL7 2.3 compliant, some segments and fields will not be used for this interface implementation. Listed below are the various triggering events and segments that include data that will be stored in Empower. This subset of HL7 segments is offered only to show which segments are important for this implementation. The Inbound Results interface can accept messages that contain any segment listed in the HL7 2.3 standard.

Message Definitions

	Unsolicited Transmission of An Observation	
R01	MSH	Message Header
	PID	Patient Identification
	PV1	Patient Visit
	ORC	Common Order
	OBR	Observation Request Segment
	NTE	Notes and Comments
	OBX	Observation/Result
	NTE	Notes and Comments

Outbound Charges

The outbound charges interface sends real-time charges information to a Billing System.



The Outbound Charges interface will send the following message trigger events.

Trigger Events

P03 Post Detail Financial Transactions

Although the Outbound Charges interface is HL7 2.2 compliant, some segments and fields will not be used for this interface implementation. Listed below are the various triggering events and segments that include data that will be sent from Empower Inpatient+Ambulatory™. This subset of HL7 segments is offered only to show which segments are important for this implementation.

Message Definitions

	Post Detail Financial Transactions	
P03	MSH	Message Header
	EVN	Event Type
	PID	Patient Identification
	FT1	Financial Transaction

Segment Definitions

MSH

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	1	ST	R		Field separator	
2	4	ST	R		Encoding characters	
3	180	HD			Sending application	
4	180	HD			Sending facility	
5	180	HD			Receiving application	
6	180	HD			Receiving facility	
7	26	TS			Date/Time of message	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
8	40	ST			Security	
9	7	CM	R		Message type	
10	20	ST	R		Message control ID	
11	3	PT	R		Processing ID	
12	8	ID	R		Version ID	
13	15	NM			Sequence number	
14	180	ST			Continuation pointer	
15	2	ID			Accept acknowledgement type	
16	2	ID			Application acknowledgement type	
17	2	ID			Country code	
18	6	ID		Y/3	Character Set	
19	60	CE			Principal Language of Message	

EVN

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	3	ID	B		Event type code	Duplicated in MSH
2	26	TS	R		Date/Time of event	
3	26	TS			Date/Time planned event	
4	3	IS			Event reason code	
5	60	XCN			Operator ID	
6	26	TS			Event Occurred	

PID

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI			Set ID – Patient ID	
2	20	CX			Patient ID (External ID)	
3	20	CX	R	Y*	Patient ID (Internal ID)	
4	20	CX		Y	Alternate Patient ID	
5	48	XPN	R	Y	Patient Name	
6	48	XPN			Mother's Maiden Name	
7	26	TS			Date of Birth	
8	1	IS			Sex	
9	48	XPN		Y	Patient Alias	
10	1	IS			Race	
11	106	XAD		Y	Patient Address	
12	4	IS			County Code	
13	40	XTN		Y	Phone Number – Home	
14	40	XTN		Y	Phone Number – Business	
15	60	CE			Language – Patient	
16	1	IS			Marital Status	
17	3	IS			Religion	
18	20	CS			Patient Account Number	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
19	16	ST			SSN Number – Patient	
20	25	DLN			Driver's Lic. Num – Patient	
21	20	CX		Y	Mother's Identifier	
22	3	IS			Ethnic Group	
23	60	ST			Birth Place	
24	2	ID			Multiple Birth Indicator	
25	2	NM			Birth Order	
26	4	IS		Y	Citizenship	
27	60	CE			Veterans Military Status	
28	80	CE			Nationality	
29	26	TS			Patient Death Date and Time	
30	1	ID			Patient Death Indicator	

PV1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI			Set ID – Patient Visit	
2	1	IS	R		Patient Class	
3	80	PL			Assigned Patient Location	
4	2	IS	*		Admission Type	
5	20	CX			Pre-admit Number	
6	80	PL			Prior Patient Location	
7	60	XCN		Y	Attending Doctor	
8	60	XCN		Y	Referring Doctor	
9	60	XCN		Y	Consulting Doctor	
10	3	IS	*		Hospital Service	
11	80	PL			Temporary Location	
12	2	IS			Pre-admit Test Indicator	
13	2	IS			Readmission Indicator	
14	3	IS	*		Admit Source	
15	2	IS		Y	Ambulatory Status	
16	2	IS			VIP Indicator	
17	60	XCN		Y	Admitting Doctor	
18	2	IS	*		Patient Type	
19	20	CX			Visit Number	
20	50	FC		Y	Financial Class	
21	2	IS			Charge Price Indicator	
22	2	IS			Courtesy Code	
23	2	IS			Credit Rating	
24	2	IS		Y	Contract Code	
25	8	DT		Y	Contract Effective Date	
26	12	NM		Y	Contract Amount	
27	3	NM		Y	Contract Period	
28	2	IS			Interest Code	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
29	1	IS			Transfer to Bad Debt Code	
30	8	DT			Transfer to Bad Debt Date	
31	10	IS			Bad Debt Agency Code	
32	12	NM			Bad Debt Transfer Amount	
33	12	NM			Bad Debt Recovery Amount	
34	1	IS			Delete Account Indicator	
35	8	DT			Delete Account Date	
36	3	IS			Discharge Disposition	
37	25	CM			Discharged to Location	
38	2	IS			Diet Type	
39	2	IS			Servicing Facility	
40	1	IS	B		Bed Status	
41	2	IS			Account Status	
42	80	PL			Pending Location	
43	80	PL			Prior Temporary Location	
44	26	TS			Admit Date/Time	
45	26	TS			Discharge Date/Time	
46	12	NM			Current Patient Balance	
47	12	NM			Total Charges	
48	12	NM			Total Adjustments	
49	12	NM			Total Payments	
50	20	CX			Alternate Visit ID	
51	1	IS			Visit Indicator	
52	60	XCN		Y	Other Healthcare Provider	

MRG

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	20	CX	R	Y	Prior Patient ID - Internal	
2	20	CX		Y	Prior Alternate Patient ID	
3	20	CX			Prior Patient Account Number	
4	20	CX			Prior Patient ID - External	
5	20	CX			Prior Visit Number	
6	20	CX			Prior Alternate Visit ID	
7	48	XPN			Prior Patient Name	

NK1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI	R		Set ID	
2	48	XPN			Name	
3	60	CE			Relationship	
4	106	XAD			Address	
5	40	XTN			Phone Number	
6	40	XTN			Business Phone Number	
7	60	CE			Contact Role	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
8	8	DT			Start Date	
9	8	DT			End Date	
10	60	ST			Job Title	
11	20	JCC			Job Code/Class	
12	20	CX			Employee Number	
13	60	XON			Organization Name	

GT1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI	R		Set ID	
2	250	CX			Guarantor Number	
3	250	XPN	R		Guarantor Name	
4	250	XPN			Guarantor Spouse Name	
5	250	XAD			Guarantor Address	
6	250	XTN			Guarantor PhNum-Home	
7	250	XTN			Guarantor PhNum-Business	
8	26	TS			Guarantor Date/Time of Birth	
9	1	IS			Guarantor Sex	
10	2	IS			Guarantor Type	
11	250	CE			Guarantor Relationship	
12	11	ST			Guarantor SSN	
13	8	DT			Guarantor Date - Begin	
14	8	DT			Guarantor Date - End	
15	2	NM			Guarantor Priority	
16	250	XPN			Guarantor Employer Name	
17	250	XAD			Guarantor Employer Address	
18	250	XTN			Guarantor Emp. Phone Number	
19	250	CX			Guarantor Employee ID Number	
20	2	IS			Guarantor Employment Status	
21	250	XON			Guarantor Organization Name	
22	1	ID			Guarantor Billing Holding Flag	
23	250	CE			Guarantor Credit Rating Code	
24	26	TS			Guarantor Death Date And Time	
25	1	ID			Guarantor Death Flag	
26	250	CE			Guarantor Charge Adj Code	
27	10	CP			Guarantor Household Income	
28	3	NM			Guarantor Household Size	
29	250	CX			Guarantor Employer ID Num.	
30	250	CE			Guarantor Marital Status Code	
31	8	DT			Guarantor Hire Eff. Date	
32	8	DT			Employment Stop Date	
33	2	IS			Living Dependency	
34	2	IS			Ambulatory Status	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
35	250	CE			Citizenship	
36	250	CE			Primary Language	
37	2	IS			Living Arrangement	
38	250	CE			Publicity Code	
39	1	ID			Protection Indicator	
40	2	IS			Student Indicator	
41	250	CE			Religion	
42	250	XPN			Mother's Maiden Name	
43	250	CE			Nationality	
44	250	CE			Ethnic Group	
45	250	XPN			Contact Person's Name	
46	250	XTN			Contact Person's Telephone Num.	
47	250	CE			Contact Reason	
48	2	IS			Contact Relationship	
49	20	ST			Job Title	
50	30	JCC			Job Class/Code	
51	250	XON			Guarantor Employer's Org. Name	
52	2	IS			Handicap	
53	2	IS			Job Status	
54	50	FC			Guarantor Financial Class	
55	250	CE			Guarantor Race	

IN1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI	R		Set ID – IN1	
2	250	CE	R		Insurance Plan ID	
3	250	CX	R	Y	Insurance Company ID	
4	250	XON		Y	Insurance Company Name	
5	250	XAD		Y	Insurance Company Address	
6	250	XPN		Y	Insurance Co. Contact Person	
7	250	XTN		Y	Insurance Co Phone Number	
8	12	ST			Group ID	
9	130	XON		Y	Group Name	
10	12	CX		Y	Insured’s Group Emp. ID	
11	250	XON		Y	Insured’s Group Emp. Name	
12	8	DT			Plan Effective Date	
13	8	DT			Plan Expiration Date	
14	250	CM			Authorization Information	
15	3	IS			Plan Type	
16	250	XPN		Y	Name of Insured	
17	2	IS			Insured’s Relationship to Patient	
18	26	TS			Insured’s Date of Birth	
19	250	XAD		Y	Insured’s Address	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
20	2	IS			Assignment of Benefits	
21	2	IS			Coordination of Benefits	
22	2	ST			Coord. of Ben. Priority	
23	2	ID			Notice of Admission Flag	
24	8	DT			Notice of Admission Date	
25	2	ID			Report of Eligibility Flag	
26	8	DT			Report of Eligibility Date	
27	2	IS			Release Information Code	
28	15	ST			Pre-Admit Cert(PAC)	
29	26	TS			Verification Date/Time	
30	250	XCN			Verification By	
31	2	IS			Type of Agreement Code	
32	2	IS			Billing Status	
33	1	NM			Lifetime Reserve Days	
34	1	NM			Delay Before L.R. Day	
35	8	IS			Company Plan Code	
36	15	ST			Policy Number	
37	12	CP			Policy Deductible	
38	12	CP			Policy Limit – Amount	
39	4	NM			Policy Limit – Days	
40	12	CP			Room Rate –Semi Private	
41	12	CP			Room Rate – Private	
42	250	CE			Insured’s Employment Status	
43	1	IS			Insured’s Sex	
44	250	XAD		Y	Insured’s Employer Address	
45	2	ST			Verification Status	
46	8	IS			Prior Insurance Plan ID	
47	3	IS			Coverage Type	
48	2	IS			Handicap	
49	250	CX		Y	Insured’s ID Number	

IN2

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	250	CX		Y	Insured’s Employee ID	
2	11	ST			Insured’s SSN	
3	250	XCN		Y	Insured’s Employer Name	
4	1	IS			Employer Information Data	
5	1	IS		Y	Mail Claim Party	
6	15	ST			Medicare Health Ins Card No.	
7	250	XPN		Y	Medicaid Case Name	
8	15	ST			Medicaid Case Number	
9	250	XPN		Y	Champus Sponsor Name	
10	20	ST			Champus ID Number	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
11	250	CE			Dependent of Champus Recipient	
12	25	ST			Champus Organization	
13	25	ST			Champus Station	
14	14	IS			Champus Service	
15	2	IS			Champus Rank/Grade	
16	3	IS			Champus Status	
17	8	DT			Champus Retire Date	
18	1	ID			Champus Non-Avail Cert on File	
19	1	ID			Baby Coverage	
20	1	ID			Combine Baby Bill	
21	1	ST			Blood Deductible	
22	250	XPN		Y	Special Coverage Approval Name	
23	30	ST			Special Coverage Approval Title	
24	8	IS		Y	Non-Covered Insurance Code	
25	250	CX		Y	Payor ID	
26	250	CX		Y	Payor Subscriber ID	
27	1	IS			Eligibility Source	
28	250	CM		Y	Room Coverage Type/Amount	
29	250	CM		Y	Policy Type/Amount	
30	250	CM			Daily Deductible	
31	2	IS			Living Dependency	
32	2	IS			Ambulatory Status	
33	250	CE			Citizenship	
34	250	CE			Primary Language	
35	2	IS			Living Arrangement	
36	250	CE			Publicity Indicator	
37	1	ID			Protection Indicator	
38	2	IS			Student Indicator	
39	3	IS			Religion	
40	250	XPN			Mother’s Maiden Name	
41	250	CE			Nationality	
42	3	IS			Ethnic Group	
43	1	IS		Y	Marital Status	
44	8	DT			Insured’s Employment Start Date	
45	8	DT			Insured’s Employment Stop Date	
46	20	ST			Job Title	
47	20	JCC			Job Code / Class	
48	2	IS			Job Status	
49	250	XPN		Y	Employer Contact Person Name	
50	250	XTN		Y	Employer Contact Person Phone No.	
51	2	IS			Employer Contact Reason	
52	250	XPN		Y	Insured’s Contact Person’s Name	
53	250	XTN		Y	Insured’s Contact Person Phone No.	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
54	2	IS		Y	Insured's Contact Person Reason	
55	8	DT			Relationship to the Patient Start Date	
56	8	DT		Y	Relationship to the Patient Stop Date	
57	2	IS			Insurance Co. Contact Reason	
58	250	XTN			Insurance Co. Contact Phone No.	
59	2	IS			Policy Scope	
60	2	IS			Policy Source	
61	250	CX			Patient Member Number	
62	2	IS			Guarantor' Relationship to Insured	
63	250	XTN		Y	Insured's Telephone No – Home	
64	250	XTN		Y	Insured's Telephone No – Bus.	
65	250	CE			Military Handicapped Program	
66	2	ID			Suspend Flag	
67	2	ID			Copay Limit Flag	
68	2	ID			Stoploss Limit Flag	
69	250	XON		Y	Insured Organization Name and ID	
70	250	XON		Y	Insured Employer Org. Name and ID	
71	250	CE		Y	Race	
72	250	CE			HCFA Pat. Relationship to Insured	

ORC

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	2	ID	R		Order Control	
2	22	EI	C		Placer Order Number	
3	22	EI	C		Filler Order Number	
4	22	EI			Placer Group Number	
5	2	ID			Order Status	
6	1	ID			Response Flag	
7	200	TQ			Quantity/Timing	
8	200	CM			Parent	
9	26	TS			Date/Time of Transaction	
10	120	XCN			Entered By	
11	120	XCN			Verified By	
12	120	XCN			Ordering Provider	
13	80	PL			Enterer's Location	
14	40	XTN		Y/2	Call Back Phone Number	
15	26	TS			Order Effective Date/Time	
16	200	CE			Order Control Code Reason	
17	60	CE			Entering Organization	
18	60	CE			Entering Device	
19	120	XCN			Action By	

OBR

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI	C		Set ID – OBR	
2	75	EI	C		Placer Order Number	
3	75	EI	R		Filler Order Number	
4	200	CE			Universal Service ID	
5	2	ID			Priority	
6	26	TS	C		Requested Date/Time	
7	26	TS	C		Observation Date/Time	
8	26	TS	C		Observation End Date/Time	
9	20	CQ			Collection Volume	
10	60	XCN		Y*	Collection Identifier	
11	1	ID			Specimen Action Code	
12	60	CE			Danger Code	
13	300	ST	C		Relevant Clinical Info.	
14	26	TS			Specimen Received Date/Time	
15	300	CM			Specimen Source	
16	80	XCN		Y*	Ordering Provider	
17	40	XTN		Y/2	Order Callback Phone Number	
18	60	ST			Placer Field 1	
19	60	ST			Placer Field 2	
20	60	ST			Filler Field 1	
21	60	ST	C		Filler Field 2	
22	26	TS			Results Rpt/Status Change Dt/Tm	
23	40	CM			Charge To Practice	
24	10	ID	C		Diagnostic Serv. Section ID	
25	1	ID			Result Status	
26	400	CM			Parent Result	
27	200	TQ		Y*	Quantity/Timing	
28	150	XCN		Y/5	Result Copies To	
29	150	CM			Parent Number	
30	20	ID			Transportation Mode	
31	300	CE		Y*	Reason for Study	
32	200	CM			Principal Result Interpreter	
33	200	CM		Y	Assistant Result Interpreter	
34	200	CM		Y	Technician	
35	200	CM		Y	Transcriptionist	
36	26	TS			Scheduled Date/Time	
37	4	NM			Number of Sample Containers	
38	60	CE		Y	Transport Logistics of Coll. Sample	
39	200	CE		Y	Collector’s Comment	
40	60	CE			Transport Arrange. Responsibility	

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
41	30	ID			Transport Arranged	
42	1	ID			Escort Required	
43	200	CE		Y	Planned Patient Transport Comment	

OBX

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	10	SI			Set ID – OBX	
2	2	ID	R		Value Type	
3	590	CE	R		Observation Identifier	
4	20	ST	C		Observation Sub-Id	
5	65536	*	C	Y	Observation Value	
6	60	CE			Units	
7	10	ST			References Range	
8	5	ID		Y/5	Abnormality Flags	
9	5	NM			Probability	
10	5	ID		Y	Nature of Abnormal Test	
11	1	ID	R		Observation Result Status	
12	26	TS			Date Last Obs. Normal Values	
13	20	ST			User Defined Access Checks	
14	26	TS			Date/Time of the Observation	
15	60	CE			Producer's Id	
16	80	XCN			Responsible Observer	
17	60	CE		Y	Observation Method	

AL1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI	R		Set ID – AL1	
2	2	IS			Allergy Type	
3	60	CE	R		Allergy Code/Mnemonic/Description	
4	2	IS			Allergy Severity	
5	15	ST			Allergy Reaction	
6	8	DT			Identification Date	

NTE

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI			Set ID - NTE	
2	8	ID			Source of Comment	
3	64k	FT		Y	Comment	

FT1

SEQ	LEN	DT	OPT	RP#	ELEMENT NAME	NOTES
1	4	SI			Set ID – FT1	
2	12	ST			Transaction ID	
3	10	ST			Transaction Batch ID	
4	26	TS	R		Transaction Date	
5	26	TS			Transaction Posting Date	
6	8	IS	R		Transaction Type	
7	80	CE	R		Transaction Code	
8	40	ST	B		Transaction Description	
9	40	ST	B		Transaction Description – Alt	
10	6	NM			Transaction Quantity	
11	12	CP			Transaction Amount – Extended	
12	12	CP			Transaction Amount – Unit	
13	60	CE			Department Code	
14	60	CE			Insurance Plan ID	
15	12	CP			Insurance Amount	
16	80	PL			Assigned Patient Location	
17	1	IS			Fee Schedule	
18	2	IS			Patient Type	
19	60	CE		Y	Diagnosis Code	
20	120	XCN			Performed By Code	
21	120	XCN			Ordered By Code	
22	12	CP			Unit Cost	
23	22	EI			Filler Order Number	
24	120	XCN			Entered By Code	
25	80	CE			Procedure Code	

Appendix 1A: Hospital Staff Contact Information

Identifying hospital leadership and the implementation team whose resources will be impacted by Empower is essential to its success. Please complete the table below within one week of contract signing and email it to the Empower Project Manager assigned to your hospital.

Title	Name	Phone	Email
Administration			
CEO			
CFO			
CIO			
CNO			
COO			
Directors/Managers			
Billing			
ED Medical Director			
ED Nurse Manager			
Information Systems			
Laboratory			
Marketing/Public Relations			
Medical Records			
Pharmacy			
Quality Assurance			
Radiology			
Registration			
Risk Management			
Other Key Project Resources			
Clinical Analyst			
Hardware Specialist			
Interface Resource or			
LIS Analyst			
Network Administrator			
Project Manager			
SQL/Database Admin			
Systems Analyst			
Unit Clerk/s			

Appendix 1B: Implementation Project Timeline Check List

Status	Task	SubTask/Checklist	Resource
Phase I - Project Kickoff + Assessment			
	Introductory Call: Project Team	Agenda to Include	EmpowerSystems™
		Identify potential weekly phone conference	EmpowerSystems™
		Identify potential target Go-Live date	EmpowerSystems™
		Identify potential changes to standard project plan	EmpowerSystems™
	Project Packet Prepared/Shipped	Materials to include	PM
		Implementation Manual	PM
		Reference Material	PM
		Projected Project Timeline	PM
	PM to PM Call	Agenda to Include	PM
		Confirm Packet receipt	PM
		Review Packet	PM
		Set expectations and identify resources	PM
	IT Conference Call		EmpowerSystems™+ Hosp IT
		Hardware	EmpowerSystems™+ Hosp IT
		Connectivity	EmpowerSystems™+ Hosp IT
		Security	EmpowerSystems™+ Hosp IT
		Interfaces	EmpowerSystems™+ Hosp IT
		Timeline	EmpowerSystems™+ Hosp IT
		Specs	EmpowerSystems™+ Hosp IT
	Purchase Hardware		Hospital
	Team Conference Call	Agenda to Include	Everyone
		Identify registration interface capabilities	Everyone
		Choose EmpowerSystems™ Kick Off Meeting	Everyone
		Identify Hospital Workflow Team	Hospital
Phase II- Data Collection and Application Development			
	Provide Hospital Data		Hospital
		Laboratory Dictionary	Hospital
		Radiology Dictionary	Hospital

Status	Task	SubTask/Checklist	Resource
		ED Charges Nursing Inventions/Procedures and RN LOS Dictionary	Hospital
		Question and Responses Laboratory	Hospital
		Question and Responses Radiology	Hospital
		PCP Demographic and Contact Information with Fax Number and secure Email addresses	Hospital
		EM Physicians Signature and DEA Number and HIS Order Entry Identification Number	Hospital
		List of ED staff and HIS logins	Hospital
		List of ED room numbers	Hospital
		List of Triage Categories	Hospital
		Sample messages for interfaces	Hospital
		Map of zones/exam rooms	Hospital
	Hardware Received		
	Operating System and Support Software Installation		
		Hospital Confirms MS Operating System Never Logs Off user to prevent PDF Generator Shut Down	Hospital
		Hospital Confirms MS Operating System Password Never Changes to prevent PDF Generator Shut Down	Hospital
		EmpowerSystems™ submits Scanner DLL for Hospital	EmpowerSystems™
Optional		Hospital Installs MS Internet Information Services(IIS) & open SMTP Ports or provide Email Exchange Server-and /Provide SMTP Address	Hospital
Optional		Hospital Installs Scanner DLL and Tests Scanning into EmpowerSystems™	EmpowerSystems™+ Hosp IT
		Hospital Installs EmpowerSystems™ Launcher on every Client Computer from the ECDS Shared Folder	Hospital
		Hospital Installs Support Software on Server for MS Operating System 2000 must install Microsoft Data Access Components (MDAC) 2.8 and also install Dot Net Framework 1.1 or greater (XP OS already has these tools)	Hospital
		Hospital Sets the Display Screen on Computer Monitor 1024x768 resolution	Hospital
	System Connectivity		Hospital
		Hospital Provides High Speed Internet Access VPN (Only MS Virtual or Cisco VPN) with Logins and Passwords	Hospital
		Hospital Provides High Speed Internet Access Remote Software connection (Only MS Remote Desktop or PC Anywhere) and with Logins and Passwords	Hospital
	EmpowerSystems™ Software Installation Test and Live		
		Install EmpowerSystems™	EmpowerSystems™

Status	Task	SubTask/Checklist	Resource
		Install EmpowerSystems™ Table Editor	EmpowerSystems™
		Install EmpowerSystems™ Complex Report Writer	EmpowerSystems™
Optional		Install and Tests Faxing Software to PCP Offices	EmpowerSystems™
Optional		Install and Tests Emailing Software to PCP Email Accounts	EmpowerSystems™
		Install PDF Generator	EmpowerSystems™
		Test Automatic EmpowerSystems™ Pager	EmpowerSystems™
	EmpowerSystems™ Table Building		
	CPOE/Charge Capture	EmpowerSystems™ will Order Diagnostic Tests using hospitals mnemonics	EmpowerSystems™
	Diagnostic Results Table	EmpowerSystems™ will identify the correct Diagnostic Results using the hospitals mnemonics	EmpowerSystems™
Phase III - Testing, Training, and Technical Readiness			
	Workflow and Training		EmpowerSystems™-SF
		Discuss Workflow Issues on Site Evaluation	EmpowerSystems™-SF
		Determine Nurse Onsite Training Dates	EmpowerSystems™-SF
		Send Nurses Training Power Point Presentation Starter Kit	EmpowerSystems™-SF
		Choose Physician Internet Training Dates	EmpowerSystems™-SF
		Send Physician Training Power Point Presentation Starter Kit	EmpowerSystems™-SF
		Training Nurses-Hospital Coordinate and schedule Nurse Training	EmpowerSystems™-SF
		Training Physicians-Hospital Coordinate and schedule Physician Training	EmpowerSystems™-SF
		Deadline for Front end user training	EmpowerSystems™-SF
	EmpowerSystems™ Meeting	Meet to discuss EmpowerSystems™ impacts departments	
		EmpowerSystems™ meets and presents EmpowerSystems™ to Hospital Coders	EmpowerSystems™
		EmpowerSystems™ meets and presents EmpowerSystems™ to Laboratory Director	EmpowerSystems™
		EmpowerSystems™ meets and presents EmpowerSystems™ to Radiology Director	EmpowerSystems™
		EmpowerSystems™ meets and presents	EmpowerSystems™

Status	Task	SubTask/Checklist	Resource
		EmpowerSystems™ to Pharmacy Director	
		EmpowerSystems™ meets and presents EmpowerSystems™ to HIM	EmpowerSystems™
		EmpowerSystems™ meets and presents EmpowerSystems™ to QA and Risk Management	EmpowerSystems™
		EmpowerSystems™ meets and presents EmpowerSystems™ to Registration and Unit Clerks	EmpowerSystems™
	Interface Build and Test		
		Hospital imports ED PDF Chart using Hospital Document Imaging & Management System	Both
		Registration Interface Building and Testing-EmpowerSystems™ Portion	Interface Team
		Registration Interface Building and Testing-Hospital Portion	Interface Team
		Diagnostic Results interface Building and Testing-EmpowerSystems™ Portion	Interface Team
		Diagnostic Results interface Building and Testing-Hospital Portion	Interface Team
		CPOE/Charge Capture Interface testing-Always Last Interface to be Built & Tested-EmpowerSystems™ Portion	Interface Team
		CPOE/Charge Capture Interface testing-Always Last Interface to be Built & Tested-Hospital Portion	Interface Team
Phase IV - Go-Live			
	Go Live Countdown		
		Monday Walk Through	EmpowerSystems™
		Pre-Go Live task list	PM
		Arrange for office near or a computer in ED with remote software connection to EmpowerSystems™ Server for support	Hospital IT
		Tracking Systems Installation for other ED areas and Departments During Go Live Week	EmpowerSystems™
	EmpowerSystems™ Go Live	EmpowerSystems™ Go Live	EmpowerSystems™
		Install EmpowerSystems™ Table Editor on assigned Hospital Employee Computers During Go Live Week	EmpowerSystems™
		Train Hospital Employee on EmpowerSystems™ Table Editor During Go Live Week	TBD
Optional		Configure BioAlert (If requested)	EmpowerSystems™
Phase V - Post GoLive Assessment and Transition			
	EmpowerSystems™ Senior Checkout meeting During Go	Go Live Evaluation and Review	EmpowerSystems™ Admin + Hosp Exec

Status	Task	SubTask/Checklist	Resource
	Live Week Thursday		Team
	CPOE/Charge Capture Interface Go Live	See EmpowerSystems™ Implementation Manual	

Appendix 2A: Business Agreement

This agreement is between EmpowerSystems™ (Empower) and the hospital.

Empower will be accessing confidential healthcare information on the medical evaluation and treatment of patients in the Emergency Department:

Empower agrees to the following:

- To treat patient healthcare information as confidential.
- To use the information only for the purpose of providing the service for which ECDS is under contract with the hospital.
- To disclose the information only to the business/business associate's employees who need access to the information in order to provide the services under the contract and who have signed an agreement requiring those employees to keep the information in confidence.
- To return the information in usable form upon request or upon completion of the work contract.

SIGNATURES:

Hospital Representative: _____

Date: _____

Empower Representative: _____

Date: _____

Appendix 3A: Empower RN Skills Verification

Trainee Name: _____ Date: _____

Training verified by: _____

General

- ❑ Log In and Change Password
- ❑ Add Patient (ex. John Doe)
- ❑ Modify patient tracker by nurse, by room number, change from alphabetical order to room number order, how to change initials from one primary RN to another, put multiple patients in one room, change room number.
- ❑ Enter information in Triage I to expedite care of critical patient:
- ❑ PCP: unk
- ❑ Chief Complaint: Unk or, i.e. Chest Pain
- ❑ Infection Control: Unk
- ❑ Allergies: Unk
- ❑ Return to Patient Tracking
- ❑ Complete Triage I, II, and III. Understands JCAHO requirements and rationale.
- ❑ Note diagnostic orders within the scope of job description and hospital policy.
- ❑ Document individual medical orders/interventions and use of standard order sets.
- ❑ Document verbal orders per hospital policy.
- ❑ Document response/cancel/refused to medical orders/interventions.
- ❑ Document nursing note, change time, change date.
- ❑ Document nursing diagnosis/expected outcome/goal achieved and rationale
- ❑ Document consulting physician notifications.
- ❑ View scan and delete scanned documents.
- ❑ View physician assessments, and old records.
- ❑ View/modify discharge instructions and check prescriptions.
- ❑ Print all, temporary triage, and respond to prompts, print chart.
- ❑ Understands safety prompts are built into the print menu.
- ❑ Understands the prompt for abnormal VS and appropriate use of override.
- ❑ Print copies of orders for ancillary, RN and ED use. med/pharmacy orders.
- ❑ Medication Reconciliation process in EmpowerSystems™.
- ❑ Demonstrates use of bed manager.
- ❑ Edit ED Staff (Super-User)

Appendix 3B: Empower Tech Skills Verification

Trainee Name: _____ Date: _____

Training verified by: _____

General

- ❑ Log In and Change Password
- ❑ Add Patient (ex. John Doe)
- ❑ Modify patient tracker by nurse, by room number, change from alphabetical order to room number order, how to change initials from one primary RN to another, put multiple patients in one room, change room number.
- ❑ Enter Repeat Vital Signs, noting ability to change time and date
- ❑ Note diagnostic orders within the scope of job description and hospital policy. (For UC/ ED Tech see hospital policy to be determined)
- ❑ Document nursing note, change time, change date. add note in Nurses Notes within scope of job description.
- ❑ Document consulting physician notifications.
- ❑ View scan and delete scanned documents.
- ❑ View physician assessments, and old records.
- ❑ Print copies of orders for ancillary, RN and ED use. med/pharmacy orders.
- ❑ Demonstrates use of bed manager.

Appendix 3C: Empower MD Skills Verification

Trainee Name: _____ Date: _____

Training verified by: _____

Login & Tracking Board	Medical Interventions
❑ Log In and Change Password	❑ Standard Order Sets
❑ Name appears in lower left corner	❑ Ordering Diagnostics in Medical Interventions
Review Tracking Board	❑ Verbal orders/Orders entered by nursing
❑ Adding initials	❑ Avoid free-text if able
❑ Sort by initials	❑ Acknowledging verbal/nursing orders
❑ Sort by Exam Room	❑ Print Nurses Orders (Consider CPOE)
❑ N and E for UBERM	❑ Medication Allergy Alert
❑ R, D and C	❑ Medication Interaction Alert
❑ Viewing Labs	**Lacerations and Other Procedures**
❑ Gray buttons	❑ Coding impact
❑ Room number sort	❑ IV infusion time
Select Patient	❑ Choosing from lists only
❑ Chief Complaint (must select from the list)	**Notifications**
❑ Social History	❑ Trauma requirement
❑ Use of lists, the art of scrolling	❑ Use of N/A
❑ Free-text guidelines	**Diagnoses**
Reviewing the chart	❑ Coding impact
❑ Review Triage (3 screens)	❑ Chief complaint as default first diagnosis
❑ View Old Records	❑ Required second diagnosis
❑ View Nurses Notes and Repeat Vital signs	**Discharge Instructions**
❑ Responses to Medical Interventions	❑ Additional Information
❑ Scanned documents	❑ Prescription Writer
Physical Exam	❑ Work and School Release
❑ Left side is normal statements	**Set Chart Ready to Print**
❑ Right side is more options	❑ Smart Technology
❑ Repeat Physical Exams	❑ Scoring Chart
Diagnostics	❑ Medical Decision Making
❑ Check boxes	**Chart Addendums**
❑ Nonstandard Tests	❑ Culture/Rad/Other follow up
❑ Reviewing Results (with & without Interface)	❑ Return Patient to Tracker
❑ Print Nurses Orders (Consider CPOE)	❑ Document in Repeat Physical Exam
❑ Only able to choose from lists	❑ Remove from tracker and PDF is updated
	❑ Transcription guidelines
	❑ Table Edits per hospital designee
	❑ Report Writer
	❑ Chart Audits by Super-users

Appendix 3D: Physician Electronic Signature

Empower will automatically sign the ED chart and prescriptions (if allowed by your state pharmacy board) for the physician.

First, Middle, Last Name, Credentials_____
Please Print Legibly: ex. John Q. Medicine, DO

DEA Number _____(If preferred to be electronically included on Rx)
User ID _____(Usually same as host HIS system)
Start Date _____

Physician Signature/s

Please sign your name **below** exactly as you would like it to appear as this will be digitized and imported into the system.

Please avoid writing on the lines

Additional boxes are “just in case” if used, identify preferred signature.

Appendix 4A: Computer Documentation Abbreviations

Abbreviation	Interpretation
History	
HA	Headache
GU	Genitourinary Tract
GI	Gastrointestinal Tract
ENT	Ear Nose Throat
CAD	Coronary Artery Disease
HTN	Hypertension
CHF	Congestion Heart Failure
CVA	Cerebral Vascular Accident
L	Left
R	Right
B	Bilateral
XRT	Radiation Treatment
LNMP	Last Normal Menstrual Period
PVD	Peripheral Vascular Disease
SLE	Systemic Lupus Erythematosus
HD MWF	Hemodialysis Mon Wed Fri
HD T Th S	Hemodialysis Tues Thur Sat
LD	Last Dose
LD	Last Drink
SOB	Shortness of Breathe
DOE	Dyspnea on Exertion
PND	Paroxysmal Nocturnal Dyspnea
FB	Foreign Body
c	With
S	Without
RLE	Right Lower Extremity
LLE	Left Lower Extremity
RUE	Right Upper Extremity
LUE	Left Upper Extremity
BLE	Bilateral Upper Extremity
LIF	Left Index Finger
LMF	Left Middle Finger
LRF	Left Ring Finger
LPF	Left Pinky Finger
RIF	Right Index Finger
RMF	Right Middle Finger
RRF	Right Ring Finger
RPF	Right Pinky Finger

Abbreviation	Interpretation
NA	Non-Applicable
Assx	Associated Symptoms
BLE	Bilateral Lower Extremity

Abbreviation	Interpretation
Physical Exam	
General Appearance	
A	Alert
O	Oriented
Ox1	Oriented Self
Ox2	Oriented Self & Time
Ox3	Oriented Self, Time & Place
Skin	
No Abbreviations	
HEENT	
HEENT	Head Ears Eyes Nose Throat
FB	Foreign Body
TM	Tympanic Membrane
L	Left
R	Right
d/c	discharge
MMM	Moist Mucous Membranes
DMM	Dry Mucous Membranes
PERRL	Pupils Equal Round Reactive Light
EOMI	Extra Ocular Muscles Intact
NT	Non-Tender
Neck	
ROM	Range of Motion
TMG	Thyroid Megaly
SQ	Subcutaneous
Cardiac	
DEM	Diastolic Ejection Murmur
SEM	Systolic Ejection Murmur
RRR	Regular Rate Rhythm
IRR	Irregular Rate Rhythm
Lung	
BS	Breath Sounds
CTA	Clear too Auscultation
Ret	Retractions
Poor AM	Poor Air Movement
“+”	Positive
“-“	Negative

Abbreviation	Interpretation
Chest Wall	
LLSB	Left Lower Sternal Border
RLSB	Right Lower Sternal Border
BLSB	Bilateral Lower Sternal Border
Abdomen	
BS	Bowel Sounds
WNL	Within Normal Limits
RLQ	Right Lower Quadrant
LLQ	Left Lower Quadrant
RUQ	Right Upper Quadrant
LUQ	Left Upper Quadrant
BUQ	Bilateral Upper Quadrant
BLQ	Bilateral Lower Quadrant
PS	Peritoneal Signs
c	With
s	Without
Dist	Distention
Genital Exam	
Cx	Cervix
CMT	Cervical Motion Tenderness
Ut	Uterus
Adx	Adnexa
"+"	Positive
"-"	Negative
CxOs	Cervical Os
Extremities	
BLE	Bilateral Lower Extremity
RLE	Right Lower Extremity
LLE	Left Lower Extremity
RUE	Right Upper Extremity
LUE	Left Upper Extremity
BLE	Bilateral Upper Extremity
LIF	Left Index Finger
LMF	Left Middle Finger
LRF	Left Ring Finger
LPF	Left Pinky Finger
RIF	Right Index Finger
RMF	Right Middle Finger
RRF	Right Ring Finger
RPF	Right Pinky Finger
AC Joint	Acromio-Clavicular Joint
DIP	Distal Inter Phalanges
PIP	Proximal Inter Phalanges

Abbreviation	Interpretation
IP	Inter Phalanges
MCP	Meta Carpal Phalanges
DIPJ	Distal Inter Phalanges Joint
PIPJ	Proximal Inter Phalanges Joint
IPJ	Inter Phalanges Joint
MCPJ	Meta Carpal Phalanges Joint
MTP	Meta Tarsal Phalanges
MTPJ	Meta Tarsal Phalanges Joint
BP	Brachial Pulse
RP	Radial Pulse
FP	Femoral Pulse
PP	Popliteal Pulse
DP	Dorsal is Pedis Pulse
PT	Posterior Tibialis Pulse
AROM	Active Range of Motion
PROM	Partial Range of Motion
CBR	Capillary Blood Refill
Neuro	
MMG	Major Muscle Groups
Ext	Extremity
MAE=B	Moves All Extremities Equal Bilaterally
BLE	Bilateral Lower Extremity
RLE	Right Lower Extremity
LLE	Left Lower Extremity
RUE	Right Upper Extremity
LUE	Left Upper Extremity
BLE	Bilateral Upper Extremity
2pt	Two point discrimination
PP	Pin Prick
Prop	Proprioception
NL	Normal
SLR	Straight Leg Raise
XSLR	Cross Straight Leg Raise
F/N intact	Finger to Nose Intact
H/S	Heel/ Shin Intact
GSS intact	Gross Sensory System Intact
Miscellaneous	
CM	Cardiac Monitor
Exp	Explored

Appendix 9A: Empower Table Names and Descriptions

The Empower look-up tables are listed below. These tables are pre-populated with the common clinical terminology used by physician and nurses when documenting on the chart. In addition, some tables are used by the smart technology built into Empower. The hospital will have an Empower table editor only to those tables not affected by the smart technology. Each field on an Empower form is connected to a look-up table. The hospital can identify the look-up table that is connected to a field on the form by reading the table description and then finding it on the Empower forms. Empower recommends only populating tables and not deleting tables.

tblluALDrugs	This table contains drug allergy and classification
tblluApplicationSettings	This table contains the on and off switch for certain hospital specific features in EmpowerSystems™.
tblluBelongDiagnostic	This table Check Boxes on the physician diagnostic form with specific tests.
tblluDiagMapping	This table groups certain diagnostic studies in order for smart technology to functions
tblluDIRx	This is table contains the physician prescriptions
tblluDIRxRefills	This table documents the number of default refills
tblluDischInstAddComments	This table conditions prewritten statements for the additional comments on the discharge form.
tblluDischInstrFollowUpOther	This table contains prewritten discharge instructions name and maps it to the hospital preferred name
tblluDischInstWorkSchool	This table contains information on when to return to work or school
tblluDischInstWorkSchoolRestriction	This table contains information on any work or school restrictions or limitations.
tblluDrug2Drug	This table contains drug to drug information and group classifications.
tblluERSort	This table allows areas in the emergency department to be designated and sort on the tracking system.
tblluExamRoom	This table lists all exam rooms in the emergency department
tblluGenGender	This table lists the patient gender options.
tblluGenLanguage	This table lists different languages a patient might speak.
tblluGenLivesWith	This table list the different types of living arrangements.
tblluGenLowMedHigh	This table lists the options for the assessing the Patient's, Parent or Child readiness to learn.
tblluGenNegPos	This table contains the yes or no options for physician review of systems.
tblluGenPlace	This table list options for the triage I injury location field.
tblluGenTimeUnits	This table list options for physician HPI onset of symptoms
tblluGroups	Allows EmpowerSystems™ to assign role base options
tblluHospital	This table contains the on and off switch for certain hospital specific features in EmpowerSystems™.
tblluLabResultsABG	This table contains the different types of result interpretations for the diagnostic study ABG.
tblluLabResultsAmylaseLipase	This table contains the different types of result interpretations for the diagnostic study Amylase & Lipase
tblluLabResultsBloodCulture	This table contains the different types of result interpretations for the diagnostic study Blood Culter
tblluLabResultsBMPChem7	This table contains the different types of result interpretations for the diagnostic study Basic Metabolic Panel/Chem7/Asterix
tblluLabResultsCardiacMarkers	This table contains the different types of result interpretations for the diagnostic study Cardiac Markers
tblluLabResultsCBC	This table contains the different types of result interpretations for the diagnostic study CBC

tblluLabResultsCTScan	This table contains the different types of result interpretations for the diagnostic study Advance Radiology Studies
tblluLabResultsEKG	This table contains the different types of result interpretations for the diagnostic study EKG
tblluLabResultsETOH	This table contains the different types of result interpretations for the diagnostic study ETOH
tblluLabResultsGeneral	This table contains the different types of result interpretations for the diagnostic study non standard studies
tblluLabResultsGlucoseScan	This table contains the different types of result interpretations for the diagnostic study point of care glucose scan
tblluLabResultsHgB	This table contains the different types of result interpretations for the diagnostic study point of care hemoglobin
tblluLabResultsLiverProfile	This table contains the different types of result interpretations for the diagnostic study Liver Function Studies
tblluLabResultsPeakFlow	This table contains the different types of result interpretations for the diagnostic study Peak Flow
tblluLabResultsPTPTT	This table contains the different types of result interpretations for the diagnostic study Pt& PTT
tblluLabResultsPulseOximetry	This table contains the different types of result interpretations for the diagnostic study Pulse Ox
tblluLabResultsQuantBHCG	This table contains the different types of result interpretations for the diagnostic study quantitative BHCG
tblluLabResultsURHCG	This table contains the different types of result interpretations for the diagnostic study urine pregnancy
tblluLabResultsUrinalysis	This table contains the different types of result interpretations for the diagnostic study urinalysis
tblluLabResultsUrineCulture	This table contains the different types of result interpretations for the diagnostic study Urine Culture
tblluLabResultsUrineDip	This table contains the different types of result interpretations for the diagnostic study Point of Care Urine Dip Stick
tblluLabResultsUrineTox	This table contains the different types of result interpretations for the diagnostic study urine Toxicology
tblluLabResultsUSNucScan	This table contains the different types of result interpretations for the diagnostic study
tblluLabResultsXRay	This table contains the different types of result interpretations for the diagnostic study ABG
tblluLabTestsGeneral	This table contains the different types non standard diagnostic tests
tblluLabTestsRadStudies	This table contains the different types advanced radiology tests.
tblluLabTestXRay	This table contains the different types plain x-rays
tblluMap2Map	This table maps hospital dictionary to the physician dictionary for diagnostic results
tblluMediMap	This table maps hospital dictionary to the physician dictionary for diagnostic orders
tblluNursingDx	This table lists the options for Nursing Diagnosis
tblluNursingOutcome	This table lists the options for Nursing Outcomes
tblluNursingPhrase	This table lists the options for prewritten phrases in the Nursing Note.
tblluOrderLocation	This table lists the options in the medical order section for Location-Response-Quantity field.
tblluPEDefaults	This defines the default normal physical exam (physician and nurse) based on patient age.
tblluPhysAbdAppearance	This table lists the options in the physical exam for abdominal appearance.
tblluPhysAbdBowelSounds	This table lists the options in the physical exam for abdominal auscultation.
tblluPhysAbdTenderness	This table lists the options in the physical exam during abdominal palpation.
tblluPhysBack	This table lists the options in the physical exam during of the back.
tblluPhysCardiac	This table list the options in the physical exam for cardiac auscultation
tblluPhysChest2	This table list the options in the physical exam for lung auscultation
tblluPhysChestWall	This table list the options in the physical exam for chest wall palpation

tblluPhysChiefComplaintAsx	This table lists the options in the Triage and Physician for chief complaint.
tblluPhysCondition	This table lists the options in the physical exam for condition on disposition.
tblluPhysDiagnosis	This table list the options in the for diagnosis
tblluPhysDisposition	This table list the options in the medical intervention for disposition
tblluPhysDuration	This table lists the options in the history for duration of symptoms.
tblluPhysExacerbatingFactors	This table list the options in the in history for symptoms exacerbation and improving factors
tblluPhysExtrAppearance	This table lists the options in the physical exam for extremity appearance.
tblluPhysExtremityLocation	This table lists the options in the physical exam for identifying a particular area on the extremity.
tblluPhysExtremityPulses	This table lists the options in the physical exam for extremity circulation.
tblluPhysExtremityROM	This table lists the options in the physical exam for extremity range of motion.
tblluPhysExtrPain	This table lists the options in the physical exam for extremity during palpation.
tblluPhysExtrSubLocation	This table list the options in the physical exam for identifying a specific area on the extremity
tblluPhysFrequency	This table lists the options in the in history for symptom frequency.
tblluPhysGeneralAppearance	This table lists the options in the physical exam for general appearance.
tblluPhysGU	This table lists the options in the physical exam for genital area.
tblluPhysHEENT	This table lists the options in the physical exam for Head, Eyes, Ears, Nose and Throat.
tblluPhysInterventions	This table lists the options in medical interventions for medical orders.
tblluPhysIVF	This table lists the options in medical interventions for intravenous fluids.
tblluPhysLacerationDepth	This table lists the options in the laceration note for laceration depth.
tblluPhysLacerationExploration	This table lists the options in the laceration note for laceration exploration.
tblluPhysLacerationLength	This table list the options in the laceration note for laceration length
tblluPhysLacerationLocation	This table list the options in the laceration note for laceration location
tblluPhysLacerationProcedure	This table lists the options in the laceration note for laceration procedure.
tblluPhysLacerationShape	This table lists the options in the laceration note for laceration description.
tblluPhysLocation	This table list the options in the history for location of symptoms
tblluPhysLungs	This table list the options in the physical exam for lung auscultation
tblluPhysLymphatics	This table lists the options in the physical exam for lymphatic system.
tblluPhysNeck	This table lists the options in the physical exam for the neck.
tblluPhysNeuroCoordination	This table lists the options in the physical exam for coordination.
tblluPhysNeuroMotor	This table lists the options in the physical exam for nerve motor skills.
tblluPhysNeuroSensory	This table list the options in the physical exam for the nerve sensory evaluation
tblluPhysOnset	This table list the options in the history for onset of symptoms
tblluPhysOxygen	This table list the options in medical interventions for oxygen requirements
tblluPhysPharmacyOrders	This table list the options in admission orders for medication
tblluPhysPMHx	This table lists the options in the history for other past medical history.
tblluPhysProcedures	This table list the options in the laceration note for physician procedures.
tblluPhysQuality	This table lists the options in the history for quality of the symptoms.
tblluPhysRadiations	This table lists the options in the history for radiation of the symptoms.
tblluPhysSkin	This table lists the options in the physical exam for the skin.
tblluPulseLabel	This table lists the options Vital Section/Heart Rate for the location of

	a specific pulse.
tblluQuestionResponse	This table lists the mapping of the question and responses to the core HIS.
tblluQuestions	This table list the options in the Diagnostic Order Entry for questions that are requested by the core HIS.
tblluRepeatExamPhrases	This table lists the options in the physical exam for prewritten repeat physician examinations.
tblluResponses	This table list the options in the Diagnostic Order Entry for answers that are requested by the core HIS
tblluRiskCC	This table lists the options in the High Risk Chief Complaints for symptoms.
tblluRiskDiagStudies	This table lists the options in the High Risk Chief Complaints for diagnostic studies and medical interventions.
tblluRiskDiffDx	This table list the options in the High Risk Chief Complaints for differential diagnosis.
tblluRiskPertHxNeg	This table lists the options in the High Risk Chief Complaints for pertinent negatives in history.
tblluRiskPertPhysNeg	This table list the options in the High Risk Chief Complaints for pertinent negatives in physical exam
tblluRNCharges	This table lists the mapping of the facility charges to the core HIS.
tblluRNLOSCoding	This table list the options for setting the criteria to calculate the RN level of Service
tblluRNLOSExceptions	This table lists the options to set the exceptions when calculating the RN level of Service.
tblluRoleGroup	This table lists which groups are role based.
tblluRoles	This table lists what roles have been set for the group.
tblluSecondaryDiagnosis	This table lists secondary diagnosis and ICD9 that will print on ED chart.
tblluSecondaryDiagnosisMap	This table maps the check boxes in past medical history to a secondary diagnosis.
tblluStandardOrders	This table lists the items which will display in the diagnostic and medical order sets.
tblluTriageAgeIncrements	This table lists the options in the triage history for duration of symptoms.
tblluTriageAllergies	This table list the options in the triage history for allergy to medication, animals etc.
tblluTriageArrivalMode	This table list the options in the triage I history for the patient mode of arrival to the hospital.
tblluTriageAssesment	This table list the options in the triage I history for the patient assessment and acuity.
tblluTriageAssessedDisability	This table lists the options in the triage III assessment of disability.
tblluTriageComaEye	This table lists the options in the triage II physical exam Glasgow coma sale eye opening.
tblluTriageComaMotor	This table lists the options in the triage II physical exam Glasgow coma sale motor function.
tblluTriageComaVerbal	This table lists the options in the triage II physical exam Glasgow coma sale verbal function.
tblluTriageDailyLiving	This table lists the options in the triage III for assessment of daily living needs.
tblluTriageExtrPulses	This table lists the options in the triage II physical exam for extremity circulation.
tblluTriageExtrROM	This table lists the options in the triage II physical exam for extremity range of motion.
tblluTriageGoingHomeWith	This table lists the options in the triage III for assessment of the patient transportation home.
tblluTriageHistorian	This table list the options in the triage I history for the person providing the medical information on the patient.
tblluTriageImmUTD	This table list the options in the triage I history for the immunization history.
tblluTriageInfectious	This table list the options in the triage I history for the patient infectious disease assessment.
tblluTriageIntervention	This table lists the options in the triage III for the patient fall assessment.

tblluTriageLivingConditions	This table lists the options in the triage III for assessment of how the patient lives.
tblluTriageMedDetailInfo	This table list the options in the triage I history for how the medications arrived at the hospital.
tblluTriageMeds	This table lists the options in the triage history for home medication.
tblluTriageNutrition	This table lists the options in the triage II physical exam for nutritional assessment.
tblluTriageOBLabel	This table list the options in the triage I history for pregnancy assessment.
tblluTriagePainScale	This table list the options in the triage I history for pain assessment
tblluTriagePlan	This table lists the options in the triage III for the disposition plan.
tblluTriagePsychStatus	This table lists the options in the triage II physical exam for general appearance.
tblluTriageSkinColor	This table lists the options in the triage II physical exam for skin color.
tblluTriageStaffStatus	This table list the options in the triage I history for the physician assessment on the medical staff.
tblluTriageTransportMode	This table list the options in the triage I history for the patient mode of arrival in the ED.

Appendix 13A: Workflow Procedure for CPOE Interface: Post Go-Live

The following is the recommended workflow procedure to implement during and post Go Live for Empower CPOE Interface.

Reason

Even though the Empower CPOE Interface is working, sometimes and by accident, the wrong mnemonic was provided by the hospital, mapped incorrectly, or an unexpected question was not answered correctly or deactivated. In either case, when Empower passes the Hospital's Health Information System (HIS) this incorrect or missing information that is required to order the diagnostic study, the CPOE will fail for this particular order. This procedure is implemented to immediately identify any failed CPOE orders, correct, and to fine-tune the interface. Furthermore, this procedure is designed to prevent any delays in the medical evaluation of ED patients that require diagnostic studies.

Procedure

1. After the physician orders diagnostic studies with the Empower CPOE interface, a printed hard copy of the diagnostic studies will be generated, placed on a clip board and submitted to the Unit Clerk.
2. The Unit Clerk will open the diagnostic portion of the patient's account in the Hospital's Health Information System (HIS).
3. The Unit Clerk will compare the Diagnostic Orders generated in the Hospital's Health Information System (HIS) by the CPOE interface against the printed Hard Copy of the Diagnostic Orders generated by the physician.
4. If the Unit Clerk identifies missing or incorrect diagnostic studies, the unit clerk will immediately update the Diagnostic Orders in the diagnostic studies portion of the patient's account in the Hospital's Health Information System (HIS).
5. The Unit Clerk will also keep a log of any missing or incorrect diagnostic studies ordered through the CPOE Interface.
6. The CPOE Interface Log will track the Patient's Name, Empower Diagnostic Study Name and the Hospitals Mnemonic (Message).
7. The clinical administration will fax the log to Empower at **(312) 276-8116** or email to contact@empower.md so that the discrepancies can be corrected when future diagnostic studies are ordered through the interface (thereby fine-tuning the Empower CPOE interface). The hospital will also have to assign a resource that EmpowerSystems™ can train how to update the Empower Order Entry Tables.

The procedure can be terminated after 90 days or until resolution of all discrepancies between the CPOE interface and the Printed Diagnostic Physician Orders.

Appendix 13B: Hospital Order Entry Problem Log Sheet

Document all interfaced orders that do not pass through the Order Entry interface between Empower and Health Information System. Please complete each row.

Patient Name	Account Number	Empower Order Name	Hospital Code

Appendix 13C: Diagnostic Results Interface Workflow - Post-Go Live

The following is the recommended workflow procedure to implement after the Go Live Date for Empower Diagnostic Results Interface.

Reason

Even though the Empower Diagnostic Results Interface is working, sometimes and by accident the wrong diagnostic mnemonic or result was provided by the hospital. In either case, when Empower receives the diagnostic mnemonic and/ or results from the Hospital's Health Information System (HIS), this incorrect or missing information will prevent Empower from displaying the correct diagnostic mnemonic or results to the physician. This procedure is implemented to immediately identify any failed or incorrect diagnostic mnemonic or results, correct, and to fine-tune the Diagnostic Results Interface. Furthermore, this procedure is designed to prevent any delays in the delivering the diagnostic results information to the physician in order to expedite the clinical evaluation and the patient's disposition.

Procedure

1. The physician will compare the Diagnostic Results generated off the printer from the Hospital's Health Information System (HIS) with the Diagnostic Results that are placed into Empower by the Hospital's Health Information System (HIS).
2. If the physician identifies missing or incorrect diagnostic results, the physician will immediately update the Diagnostic results in the chart in the diagnostic studies section of Empower.
3. The physician will also keep a Log of any missing or incorrect diagnostic results identified from the Diagnostic Results Interface.
4. The Diagnostic Results interface Log will track the Patient's Name and the Diagnostic Results Name.
5. The clinical administration will fax the log to Empower at (312) 276-8116 or via email at contact@empower.md so that the discrepancies can be corrected for future diagnostic results that are acquired through the interface (thereby fine-tuning the Empower Diagnostic Results interface).
6. The Diagnostic Results Interface Log will track the Patient's Name, Empower Diagnostic Study Name and the Hospitals Diagnostic Results Mnemonic/code.

The procedure can be terminated after 90 days or until resolution of all discrepancies between the Diagnostic Results Interface into Empower and the Printed Diagnostic Results from the Hospital's Health Information System (HIS).

Appendix 13D: Hospital Diagnostic Results Problem Log Sheet

Document all interfaced orders that do not pass through the Order Entry interface between Empower and Health Information System. Please complete each row.

Patient Name	Account Number	Empower Order Name	Hospital Code

Empower User Troubleshooting Guide

User Issues	Solution
Unable to type numbers using the numeric keys.	Make sure the "Num Lock" is on.
The screen is black, unable to enter anything.	Check all connections and make sure the computer is plugged in. Make sure the computer is turned on. If it is just one computer, this is an issue for your internal IT Department. If it is all computers, consult your internal IT Department before calling EmpowerSystems™.
Forgotten Password or new user without a log in or password.	Contact internal Account Administrator who has the ability to Add/Edit Staff.
Document scanned into incorrect chart.	A scan entered into the wrong patient can be deleted using the 'Delete Scan' button and scanned into the correct chart.
Unable to close/print a chart due to abnormal or repeat vital signs.	Abnormal Vital Signs allows the user to "Override" and print/close the chart. It is a gray button at the bottom center. Repeat Vital Signs are required for certain chief complaints. The override button does not appear. You must enter a repeat set of VS. If this is not possible, document NA in all VS fields (NA/NA for BP) You can type See NN in the Pain field and make an explanation of why in the NN. This will come back as an abnormal Vital Sign and the user can "Override" and print/close the chart.
Unable to close/print a chart due to request for "Trauma Notification".	The user should document NA in the notification screen for the simple trauma diagnosis that does not require a notification.
Request to merge charts for patients entered twice.	EmpowerSystems™ does not merge charts. This is a user issue. Those involved must manually remove documentation from the incorrect chart and re-enter into the correct chart. This can be done using copy and paste. The incorrect chart can be removed from the Tracker by clicking on the Disposition field.
New PCP to add to the system.	This can be done on the Discharge Instruction page (Add/Edit New Provider). This is also managed by the internal Account Administrator via table editing.
Request for Discharge	The option for Discharge Instructions only opens when the disposition

User Issues	Solution
instructions for a patient being Transferred.	of Discharge is selected by the ED physician.
Table edits and additions.	The hospital has designated staff to do these edits. Write request in the EmpowerSystems™ notebook for consideration. The additions/edits will be done internally.

EmpowerSystems™ screen too small or too large, you can't see all the fields or unable to click some of the gray buttons.	You will need to change the Display Settings on that computer. Log out of EmpowerSystems™ and click "Start" in the lower left corner. • Click Settings • Click Control Panel • Click Settings • Click Settings tab at top • Set resolution to 1024x768 by moving your mouse on the little arrow until you see these numbers. • Apply and Save Contact a super-user or Internal IT if you need assistance.
Plasma Screen blank or displays incorrect information or lacks information.	Check connections; make sure it is turned on. Reboot the computer attached to this. Try all of this prior to calling the help line.
Time incorrect on the computer.	Log out of EmpowerSystems™ and right-click on the time display and change to the correct time. Contact internal IT if unable to change the time.
Lab Results not crossing to EmpowerSystems™ or crossing slowly.	All lab diagnostics must be selected from the drop down tables if entered in Medical Interventions. If a blood test shows on the Medical Interventions screen it was free-texted and that text is not mapped. Cancel the incorrect and re-enter appropriately. If the test does appear in diagnostics contact the lab and then call the help line regarding this interface issue.
Patients not crossing to	Contact your IT department with patient examples and if they

EmpowerSystems™ via the ADT interface. (or crossing slowly)	determine it is not an internal problem, they should contact EmpowerSystems™ Technical Support.

Technical Support Guidelines

In an effort to allow Emergent calls to take precedence over Non-Emergent calls and provide more appropriate and efficient customer service, our Emergency phone support is an automated system, monitored by our technical support staff. Callers will be routed through a call script to ascertain if the issue is a true emergency and if the appropriate troubleshooting by hospital IT has been completed prior to selecting the option to leave an Emergent message for our team to respond to.

The Emergent Emergent Support Line **(877) 222-3237** is intended only to be available to hospital IT departments or designated EmpowerSystems™ clinical administrators so that appropriate on-site troubleshooting is completed prior to contacting EmpowerSystems™. The IT team should rule out network outages, hardware resources/availability, and integration prior to contacting EmpowerSystems™ on an emergent basis to avoid financial penalties.

Empower Definition of an Emergency

Clinicians in the ED unable to document on one or more patients currently active in the ED, or complete integration failure between Empower and your Core Hospital Information System (ex: ADT failure, Orders or Results not crossing for multiple patients).

Examples NOT Considered Emergencies

- **Forgotten Passwords or New User Setup** – Your hospital system administrator has been provided training to manage user accounts in Empower.
- **Printing Problems** – Empower has been set up at each site to work to the specifications identified during implementation. Any issues concerning printing should be managed through your IT department, as this is unlikely to be a result of Empower.
- **Interface Orders or Results on an Individual Patient** – Unless this issue applies to multiple patients, open a Non-Emergent ticket on our support site and include specific examples to include MR#, Account#, Date of Service, Test Examples, and what should have crossed.
- **Physician Signatures** – As of v1.7.5, Empower provided your hospital with the ability to capture and manage all signatures via tablet PC. If you have not already done so, please make arrangements to acquire a tablet PC for this purpose, as we will no longer be accepting faxed signatures for processing.
- **PDF Generation** – Empower employs notification technology to let us know when/if our PDF process is interrupted. This can naturally occur due to network errors and will be corrected quickly during normal business hours.

By calling the Emergent Emergent Support Line **(877) 222-3237**, selecting the correct option, and leaving a voice message will notify the technician on duty 24/7. This automated process takes approximately 15-20 minutes to receive a response. Again, our Non-Emergent ticket system is always available by visiting www.empower.md and choosing 'Support' in the top right corner of the web page. Additional details are on the proceeding pages. Please contact your Empower Project Manager if your team is unsure of the login and password.

Empower Emergent Support Matrix

PRIORITY	METHOD	DEFINITION	UPDATES	ESCALATION	RESOLUTION
Emergent	Emergent Call Line	System Completely Down	Continuous as Information Becomes Available	Within 2 Hours from Initial Contact	4 Hours from Initial Contact
		Issue Affecting Entire System			
		Physicians Cannot Document at All on Any Patients			
		Management Attention Required			
		Main Empower Server Failure			
Critical	Emergent Call Line	System Up with Degraded Functionality	Every 2 Hours Until Resolved	Within 4 Hours from Initial Contact	6 Hours from Initial Contact
		Entire Interface Functionality Down for All Patients			
		Interface Server Failures			

Empower Non-Emergent Support Matrix

PRIORITY	METHOD	DEFINITION	UPDATES	ESCALATION	RESOLUTION
High	Online Ticketing System	System Operational with Minor Functionality Loss Minor Subsystem Functionality Failures Limited Data Entry / Access Issues General High Impact Bug Fixes Peripheral Application Server Failures	Upon Resolution or Weekly Until Resolved	Within 24 Business Hours from Contact	32 Business Hours Depending Upon Scope and Complexity
Medium	Online Ticketing System	Minor Operational Issues Without Immediate Patient Documentation Impact Report Requests Enhancement Requests	Upon Resolution or Weekly Until Resolved	Within 36 Business Hours from Contact	40 Business Hours Depending Upon Scope and Complexity
Low	Online Ticketing System	General Assistance, Information, Training and Other Service Requests	Upon Resolution or Weekly Until Resolved	Within 48 Business Hours from contact	80 Business Hours Depending Upon Scope and Complexity

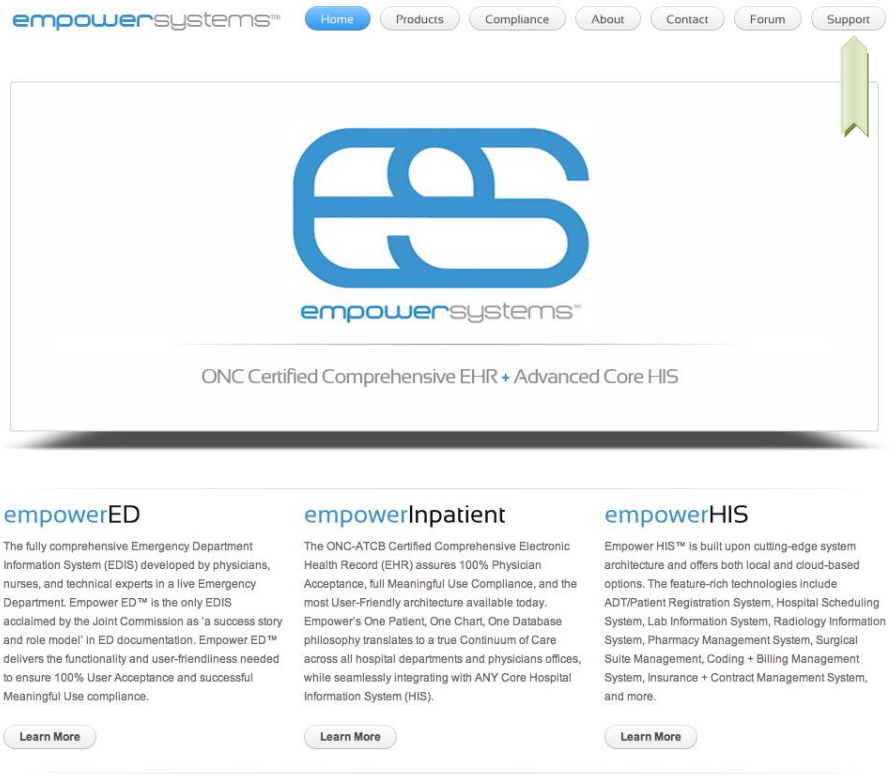
Empower Escalation + Notification Matrix

ACTION	RESPONSIBILITY	RESPONSE TIME
Identify Escalation Level	Site Support Rep (owner)	Immediate
VP of Project Management/First level Support Team Notified	Site Support Rep (owner)	30 minutes after escalation
Notification Sent to Various Levels of Mgt	Site Support Rep (owner)	30 minutes after escalation
Customer Informed of Escalation Status	Site Support Rep (owner)	30-60 minutes after escalation
Second Level Support Team Notified and Activated	VP of Project Management	4 hrs after escalation
Notification Sent to Operations and Various Levels of Mgt	VP of Project Management	Every 2hrs and with issue updates
Executive Mgt Notification	VP of Project Management	6 hrs after escalation
VP of Project Mgt/Executive Mgt Contacts the Client	VP Proj Mgt/Exec Mgt	24 hrs after escalation
Scheduled Issue Status Conference Call	Empower and Client Technical and Project Mgt Teams	As needed
Post Mortem & Follow-Up	Site Support Rep/VP of Project Mgt	1 week after issue closure

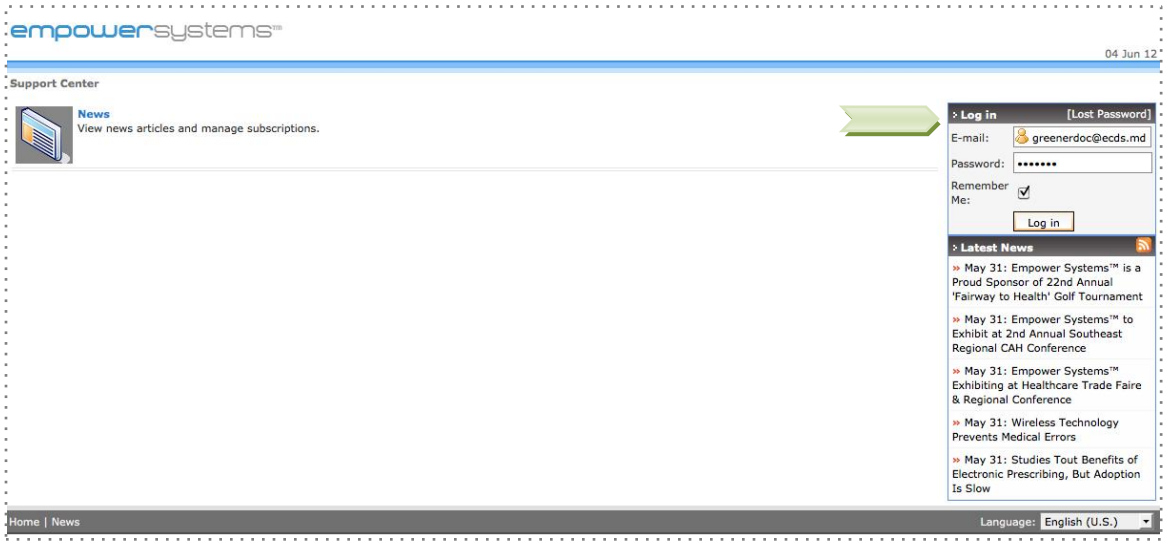
Client Support Quick Start Guide

Empower's Non-Emergent Support System is a web-based portal that can be reached by selecting the 'Support' button atop any page of the website, or simply Click Here and bookmark the URL.

Locating the Support System

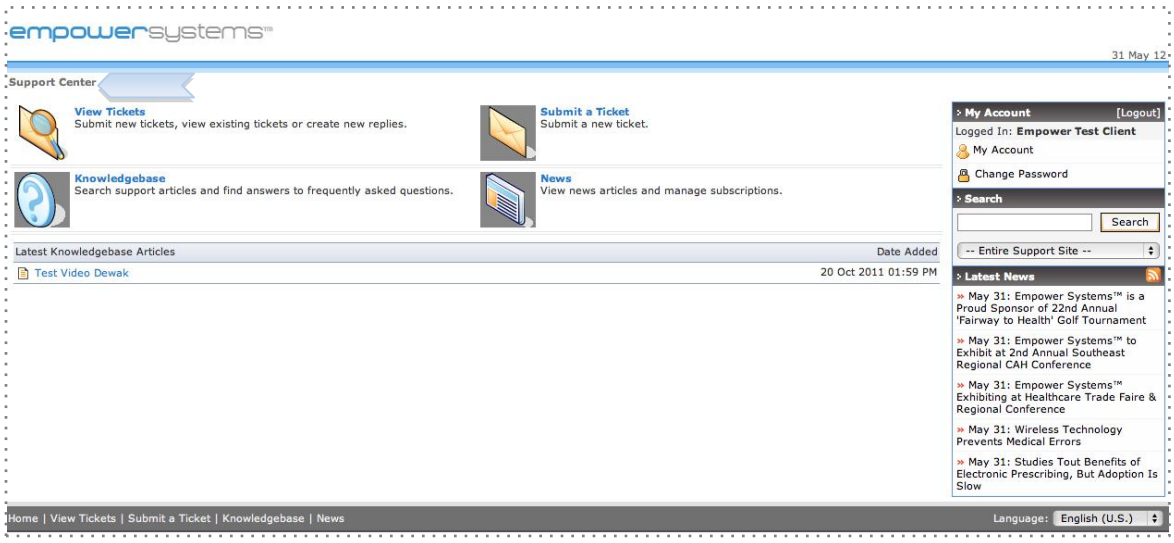

empowersystems
Home
Products
Compliance
About
Contact
Forum
Support
empowersystems
ONC Certified Comprehensive EHR + Advanced Core HIS
empowerED
The fully comprehensive Emergency Department Information System (EDIS) developed by physicians, nurses, and technical experts in a live Emergency Department. Empower ED™ is the only EDIS acclaimed by the Joint Commission as 'a success story and role model' in ED documentation. Empower ED™ delivers the functionality and user-friendliness needed to ensure 100% User Acceptance and successful Meaningful Use compliance.
Learn More
empowerInpatient
The ONC-ATCB Certified Comprehensive Electronic Health Record (EHR) assures 100% Physician Acceptance, full Meaningful Use Compliance, and the most User-Friendly architecture available today. Empower's One Patient, One Chart, One Database philosophy translates to a true Continuum of Care across all hospital departments and physicians offices, while seamlessly integrating with ANY Core Hospital Information System (HIS).
Learn More
empowerHIS
Empower HIS™ is built upon cutting-edge system architecture and offers both local and cloud-based options. The feature-rich technologies include ADT/Patient Registration System, Hospital Scheduling System, Lab Information System, Radiology Information System, Pharmacy Management System, Surgical Suite Management, Coding + Billing Management System, Insurance + Contract Management System, and more.
Learn More

Login


empowersystems
04 Jun 12
Support Center
News
View news articles and manage subscriptions.
Log in
[Lost Password]
E-mail:
greenerdoc@ecds.md
Password:
Remember Me:
Log in
Latest News
» May 31: Empower Systems™ is a Proud Sponsor of 22nd Annual 'Fairway to Health' Golf Tournament
» May 31: Empower Systems™ to Exhibit at 2nd Annual Southeast Regional CAH Conference
» May 31: Empower Systems™ Exhibiting at Healthcare Trade Faire & Regional Conference
» May 31: Wireless Technology Prevents Medical Errors
» May 31: Studies Tout Benefits of Electronic Prescribing, But Adoption Is Slow
Home | News
Language: English (U.S.)

- ✶ Each User at the hospital will have his own login and password. Use your email address as your login. Your initial password will be "welcome".
- ✶ Select ‘Remember Me’ and Click the ‘Log in’ button.
- ✶ Please reset your password immediately upon first entry.
- ✶ For quick reference, please bookmark the login page in your web browser.

Support Center


empowersystems
31 May 12
Support Center
View Tickets
Submit new tickets, view existing tickets or create new replies.
Submit a Ticket
Submit a new ticket.
Knowledgebase
Search support articles and find answers to frequently asked questions.
News
View news articles and manage subscriptions.
Latest Knowledgebase Articles
Date Added
Test Video Dewak
20 Oct 2011 01:59 PM
My Account
[Logout]
Logged In: Empower Test Client
My Account
Change Password
Search
Search
-- Entire Support Site --
Latest News
» May 31: Empower Systems™ is a Proud Sponsor of 22nd Annual 'Fairway to Health' Golf Tournament
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» May 31: Wireless Technology Prevents Medical Errors
» May 31: Studies Tout Benefits of Electronic Prescribing, But Adoption Is Slow
Home | View Tickets | Submit a Ticket | Knowledgebase | News
Language: English (U.S.)

Upon Login, you will see the Support Center page. From here you have these options:

1. **View Tickets**
   Here you can View your existing Tickets.

2. **Submit a Ticket**
   Submit a new support ticket here.

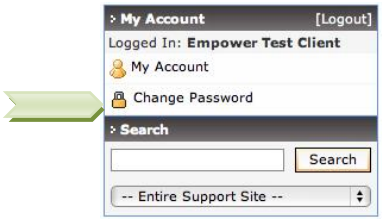
3. **Knowledgebase**
   Access the empower Knowledge base here this will also interact with you automatically during a new ticket creation process.

4. **News**
   News releases about the Empower and its products.

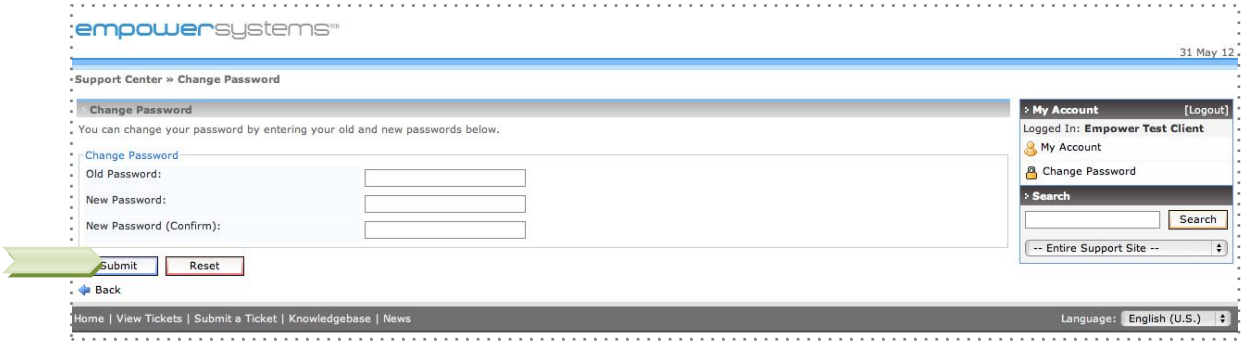
5. **My Account**
   Located on the right task bar. Change your account settings and password here.

Reset Your Password

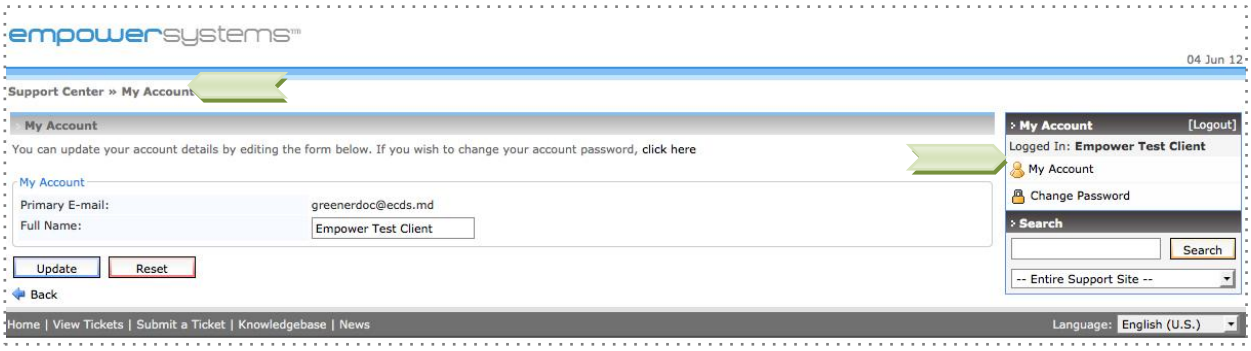
Click on the change password button in the **My Account** section.



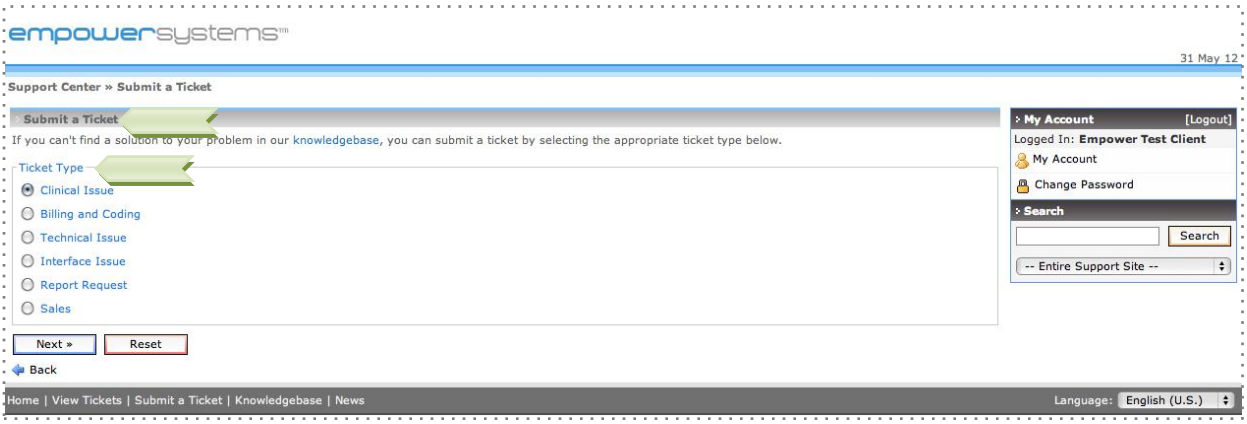
Enter your old and new passwords and click **Submit.**



By clicking on My Account you can change your email and name settings.



Submit a Ticket



Select the appropriate Ticket Type for the issue you want to submit:

Clinical Issue
Any issues of a clinical nature where clinical workflow, terminology or resources are involved.

Billing + Coding
Any issues for review by our Coding+Billing team can be posted here.

Technical Issue
Any issues of a technical nature where programmers would most like need to be involved

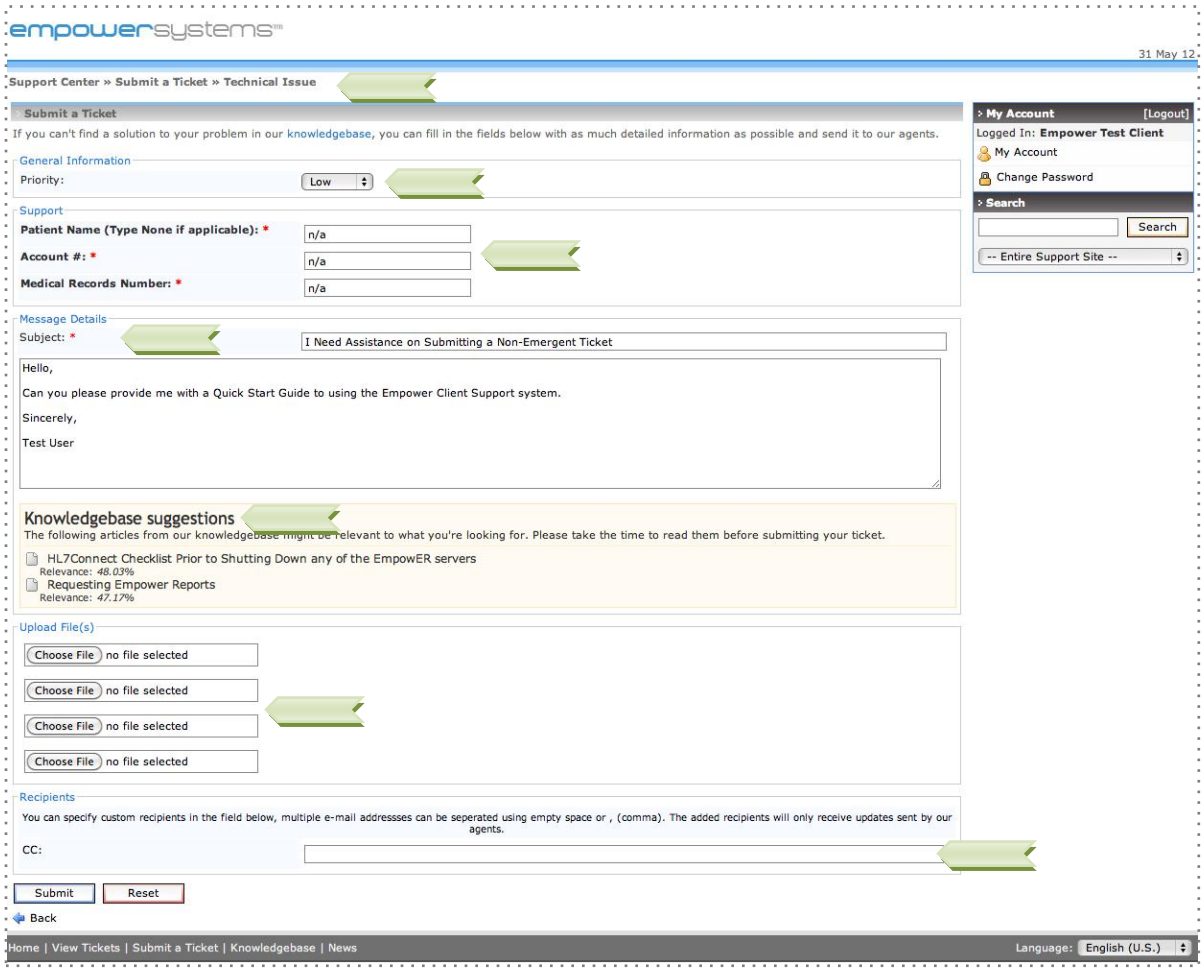
Interface Issues
Any issues involving interfaces between your Empower system and your HIS/Ancillary systems/Devices

Sales
Any question you would like relayed to our sales team can be posted here.

Report Request

Any Report-related request or inquiry.

You must fill in the required fields (with *) and then fill out the body of the ticket with whatever specifics apply.


empowersystems
31 May 12
Support Center » Submit a Ticket » Technical Issue
Submit a Ticket
If you can't find a solution to your problem in our knowledgebase, you can fill in the fields below with as much detailed information as possible and send it to our agents.
General Information
Priority:
Low
Support
Patient Name (Type None if applicable): *
n/a
Account #: *
n/a
Medical Records Number: *
n/a
Message Details
Subject: *
I Need Assistance on Submitting a Non-Emergent Ticket
Hello,
Can you please provide me with a Quick Start Guide to using the Empower Client Support system.
Sincerely,
Test User
Knowledgebase suggestions
The following articles from our knowledgebase might be relevant to what you're looking for. Please take the time to read them before submitting your ticket.
HL7Connect Checklist Prior to Shutting Down any of the EmpowER servers
Relevance: 48.03%
Requesting Empower Reports
Relevance: 47.17%
Upload File(s)
Choose File no file selected
Choose File no file selected
Choose File no file selected
Choose File no file selected
Recipients
You can specify custom recipients in the field below, multiple e-mail addressses can be seperated using empty space or , (comma). The added recipients will only receive updates sent by our agents.
CC:
Submit
Reset
Back
Home | View Tickets | Submit a Ticket | Knowledgebase | News
Language: English (U.S.)
My Account [Logout]
Logged In: Empower Test Client
My Account
Change Password
Search
Search
-- Entire Support Site --

Knowledgebase

From this example you can see that our new knowledge base will try to recognize as you type in the body of the ticket and suggest articles from our knowledge base. This is a work in progress and will improve as time goes on and more articles are added to the knowledge base.

Upload File(s)

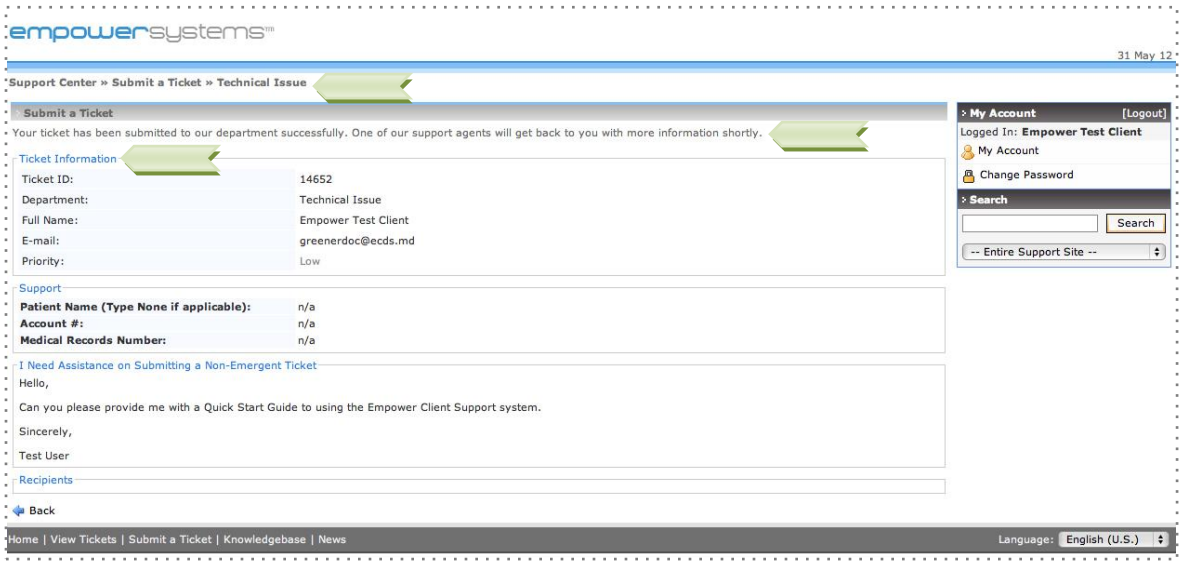
You can upload files to the ticket by browsing your computer to the file you would like to upload.

Add Recipients

You can add recipients who are not currently in the system to the ticket in the space provided and they will then be copied on all replies for that ticket only.

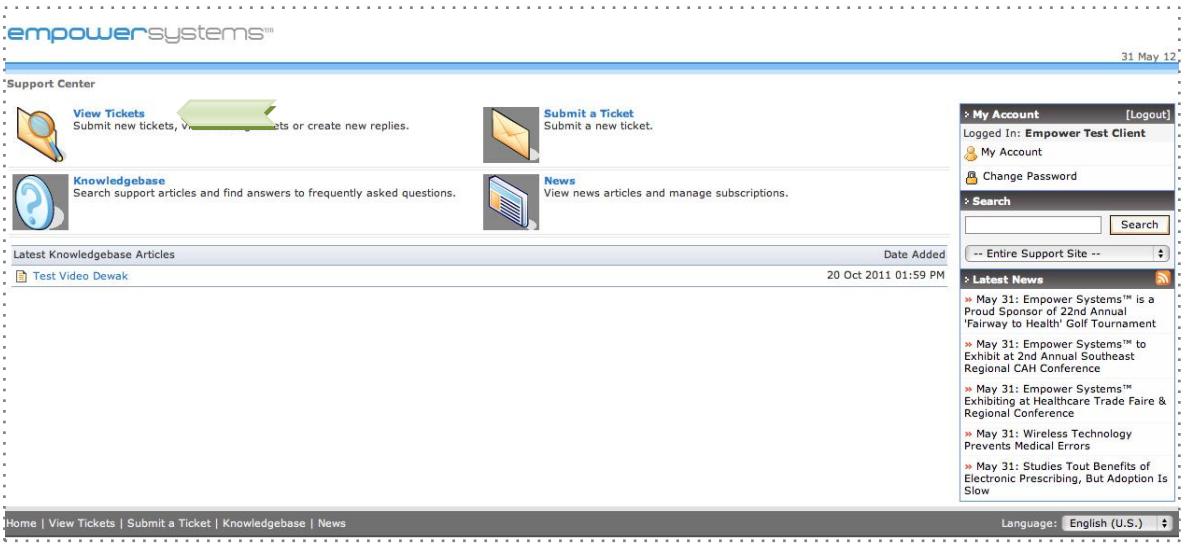
See Example below of required fields and completed content (similar to an email).

The site will show you the information once the ticket is entered.


empowersystems
31 May 12
Support Center » Submit a Ticket » Technical Issue
Submit a Ticket
Your ticket has been submitted to our department successfully. One of our support agents will get back to you with more information shortly.
Ticket Information
Ticket ID: 14652
Department: Technical Issue
Full Name: Empower Test Client
E-mail: greenerdoc@ecds.md
Priority: Low
Support
Patient Name (Type None if applicable): n/a
Account #: n/a
Medical Records Number: n/a
I Need Assistance on Submitting a Non-Emergent Ticket
Hello,
Can you please provide me with a Quick Start Guide to using the Empower Client Support system.
Sincerely,
Test User
Recipients
Back
My Account [Logout]
Logged In: Empower Test Client
My Account
Change Password
Search
Search
-- Entire Support Site --
Home | View Tickets | Submit a Ticket | Knowledgebase | News
Language: English (U.S.)

Viewing Existing Tickets

Select the "view tickets" option from the main client support page after logging in.


empowersystems
31 May 12
Support Center
View Tickets
Submit new tickets,
or create new replies.
Submit a Ticket
Submit a new ticket.
Knowledgebase
Search support articles and find answers to frequently asked questions.
News
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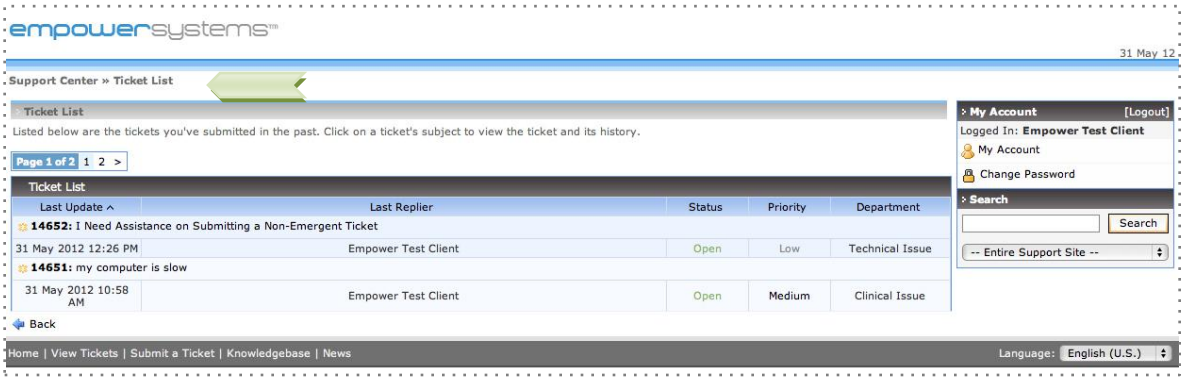
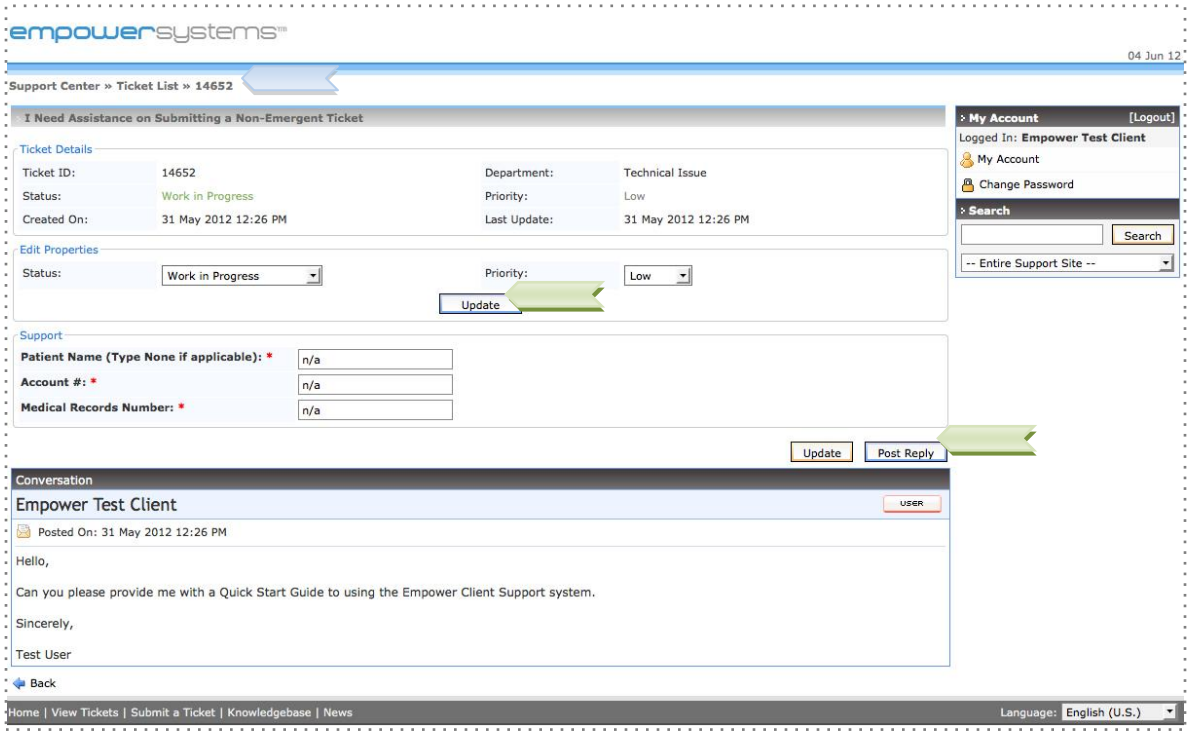
Latest Knowledgebase Articles
Date Added
Test Video Dewak
20 Oct 2011 01:59 PM
My Account [Logout]
Logged In: Empower Test Client
My Account
Change Password
Search
Search
-- Entire Support Site --
Latest News
» May 31: Empower Systems™ is a Proud Sponsor of 22nd Annual 'Fairway to Health' Golf Tournament
» May 31: Empower Systems™ to Exhibit at 2nd Annual Southeast Regional CAH Conference
» May 31: Empower Systems™ Exhibiting at Healthcare Trade Faire & Regional Conference
» May 31: Wireless Technology Prevents Medical Errors
» May 31: Studies Tout Benefits of Electronic Prescribing, But Adoption Is Slow
Home | View Tickets | Submit a Ticket | Knowledgebase | News
Language: English (U.S.)

You will be taken to a page with a list of all the tickets that you have submitted. (If you are an Empower support administrator - which most users are- you will see all tickets submitted from your hospital.)

You can click on the ticket number to open the text of a particular ticket. You can also click on the headings at the top (last update, last replier, status, priority, department) to sort by that field.



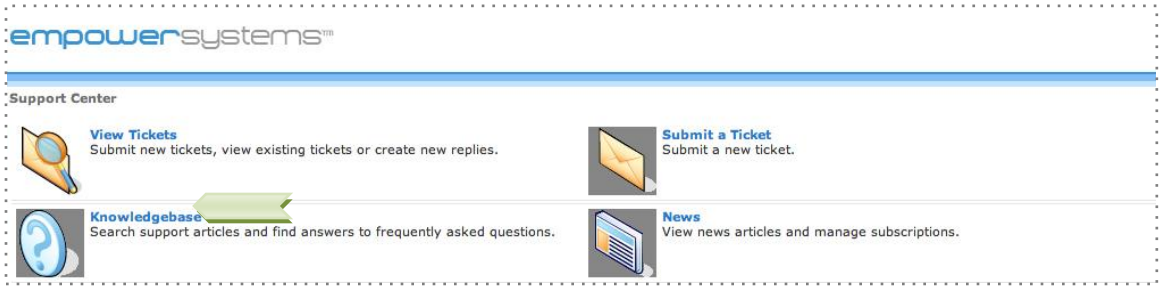
Once you click the ticket number, the ticket will open with all of the replies in the body of the ticket.



From here, you can add an update, ask another question, provide necessary information, change the status or the priority and post the reply. The reply will go to the appropriate Empower team member.

Knowledgebase

If you go back to the main support page, you can also access the Knowledgebase by clicking the link for knowledge base: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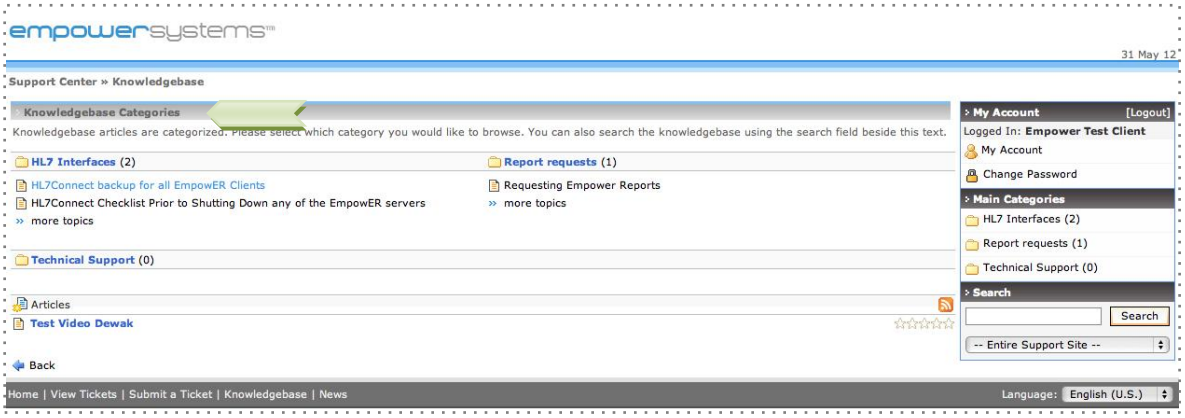
Support Center
View Tickets
Submit new tickets, view existing tickets or create new replies.
Submit a Ticket
Submit a new ticket.
Knowledgebase
Search support articles and find answers to frequently asked questions.
News
View news articles and manage subscriptions.

You will be directed to the Knowledgebase, which will show categories for articles that pertain to Empower functionality and technical issues. From here you can select the article you are interested in. You may also be directed to the article when you are submitting a ticket (as explained previously).


empowersystems™
31 May 12
Support Center » Knowledgebase
Knowledgebase Categories
Knowledgebase articles are categorized. Please select which category you would like to browse. You can also search the knowledgebase using the search field beside this text.
HL7 Interfaces (2)
HL7Connect backup for all EmpowER Clients
HL7Connect Checklist Prior to Shutting Down any of the EmpowER servers
» more topics
Report requests (1)
Requesting Empower Reports
» more topics
Technical Support (0)
Articles
Test Video Dewak
Back
My Account [Logout]
Logged In: Empower Test Client
My Account
Change Password
Main Categories
HL7 Interfaces (2)
Report requests (1)
Technical Support (0)
Search
Search
-- Entire Support Site --
Home | View Tickets | Submit a Ticket | Knowledgebase | News
Language: English (U.S.)

You are now ready to submit, track, and monitor Non-Emergent tickets for your facility! We hope this guide will serve you well as you familiarize yourself with this user-friendly resource. As always, your Empower project manager is available to discuss more specifics surrounding your Non-Emergent issues.

Empower Inpatient™ Sample Chart

Patient Demographics

Admission Data

Account Number	Medical Record	Admit Date	Admit Time	EMR MD	Primary Care MD	Admit Clerk
[redacted]	[redacted]	5/23/2011	15:33	45380 AHMED, ZAFAR	45380 AHMED, ZAFAR	

Reason For Visit	SHORTNESS OF BREATH	MN Visit Dx	
Other Doctors	AHMED,ZAFAR ; ,		
Comments			

Patient Data

Patient Name	Date of Birth	Social Security	Race	Sex	Religion	Marital	Maiden Name	Patient Email
[redacted]	[redacted]	[redacted]	[redacted]	F	BAP	M		

Address 1	[redacted]						
Address 2	[redacted]						
City	[redacted]	State	IL	Zip	60406	Phone	[redacted]
Employer	UNEMPLOYED			Occupation	UNEMPLOYED		
Address 1							
Address 2							
City		State		Zip		Phone	

Insurance Data

Insurance Name	Subscriber	Subscr ber Relationship	Policy Number	Group Number	Fin Class	Auth Number
WELLCARE	[redacted]		[redacted]	[redacted]	13	[redacted]

Address 1	P.O. BOX 31372						
Address 2	CLAIMS						
City	TAMPA	State	FL	Zip	336313372	Phone	[redacted]

Insurance Name	Subscriber	Subscr ber Relationship	Policy Number	Group Number	Fin Class	Auth Number
MEDICAID ILLINOIS	[redacted]		[redacted]	[redacted]	13	

Address 1	CLAIMS DEPT						
Address 2	PO BOX 19132						
City	SPRINGFIELD	State	IL	Zip	62794	Phone	

Person To Notify Data

Name	Relationship
[redacted]	I

Address 1									
Address 2									
City		State		Zip		Phone	[redacted]	Business Phone	

Name	Relationship
[redacted]	M

Address 1									
Address 2									
City		State		Zip		Phone	[redacted]	Business Phone	

Guarantor Data

Name	Relationship	Social Security	Employer	Occupation
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Address 1	[redacted]								
Address 2	[redacted]								
City	[redacted]	State	IL	Zip	[redacted]	Phone	[redacted]	Business Phone	

Name	Relationship	Social Security	Employer	Occupation
[redacted]	S	[redacted]	[redacted]	[redacted]

Address 1	[redacted]								
Address 2	[redacted]								
City	[redacted]	State	IL	Zip	60406	Phone	[redacted]	Business Phone	

Next Of Kin Data

Name	Relationship
[redacted]	I

Address 1									
Address 2									
City		State		Zip		Phone	[redacted]	Business Phone	

Patient Demographics

Name	Relationship
[redacted]	[redacted]

Address 1	
Address 2	

City		State		Zip		Phone	[redacted]	Business Phone	

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Admission Assessment

Weight 85.7kg **Height** 75.26cm **BMI** 27.9

Past Medical History

cardiomyopathy

Hypercholesterolemia

diabetes

refuse flu shot, pneumovax

Bronchitis

Congestive Heart Failure

Hypertension

DC AICD MEDTRONIC (MAY 13,2010)

Social History

Lives at home with Family

Smoker Former

Alcohol use- 10 years ago

Todd 773-552-3246

Family History

Unknown family history

Allergies

nka

Home Medications - Admission

Aspirin 325 mg Tab, Daily

Chlordiazepoxide 25 mg Cap, At Bedtime as needed

Colace 100 mg Cap, Twice Daily as needed

Colchicine 0.6 mg Tab, Twice A Day

Coreg 25 mg Tab, Twice A Day

Digoxin 0.25mg PO, Daily

Enalapril 20mg PO, 1 tablet, Twice A Day

Glipizide 10 mg Tab, Twice A Day

HUMALOG 6units After Meals Subcutaneous, 6 UNITS, Three times daily AFTER Meals

Insulin Detemir SubQ, 20 units, At Bedtime

Lasix 80 mg Tab, Twice A Day

Pepcid 20 mg Tab, Twice A Day

Reglan 10 mg Tab, Three Times A Day

Simvastatin 40 mg Tab, Daily

Warfarin 5 mg Tab, Daily

Zithromax 250mg PO, Daily

Advance Directives

No living will

No existing POA healthcare

No organ and tissue donor

Fall Risk

4=YES-Current/Historical Confusion/disorientation/Impulsivisity

0=NO-Current/Historical Symptomatic Depression

0=NO-Altered elimination

0=NO-Dizziness/vertigo

0=NO-Male gender

0=NO-Anti-epileptics taken

0=NO-Benzodiazepines taken

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

3= Multiple attempts but successful

TOTAL SCORE= 5 or more

HIGH FALL RISK PATIENT

Nutrition

No - Poor appetite more than 5 days

Yes - Less than 50% usual intake past 7 days

No - Recent unintentional weight loss more than 10 lbs past month

No - Diarrhea, vomiting, Hyperemesis more than 7 days

No - Receives nutrition via feeding tube or IV

No - Open, draining wounds or pressure ulcers

No - New onset diabetes

No dietary consult indicated at present

Skin Integrity

4=Sensory no limits

3=Skin occasionally moist

4=Skin rarely moist

3=Walks occasionally

3=Slight limit mobility

2=Inadequate nutrition

3=No apparent problem

NO RISK - score 19 or more

Suicide Self Harm Risk

NO - Previous psychiatric DX

NO - Prior thoughts self harm

NO - Chronic physical pain/distress

NO - Recent unemployment

NO - Recent loss of loved one

NO - Symptoms or diagnosis Post Partum depression

No further screening needed

VTE/DVT

Patient is on maintenance anticoagulation, no further assessment needed at this time.

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Notes

MD Name AHMED, ZAFAR Date of Note 05/23/2011 18:25 Note Type HISTORY AND PHYSICAL

History / Subjective

HPI Paragraph: Patient with 62 year old lady was admitted to hospital from my office because of multiple problems. She has been having weight gain and increasew in abdominal girth. She was very short of breath exertional, and progressively worsening functional status. At office she had blood glucose of 23, which inmproved to 47 upon use of a Sugar tablet. She had an episode of syncope a week ago..
Other Notes:
Review of Systems NOT Covered in HPI:
ENT: Neg,Heart: Pos,Resp: Pos,GI: Neg,GU: Neg,Skin: Neg,Neuro: Pos,Psych: Neg,Musculoskeletal: Neg,Endocrine: Pos,Hematologic/Lymphatic: Neg,Allergic/Immunologic: Neg,Constitutional Sxs: Neg,Eyes: Neg,

Exam / Objective

Date/Time of Exam: May 23 2011 6:25PM
GA: Knows month,and day,not date or year,knows the name of President, knows that she's in the office
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: NT Full ROM No JVD
Lung/Chest Wall: Lungs-Lungs CTA No Ret/Chest Wall-Chest Wall NT, AICD in place
Cardio Vascular: RRR No M
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-No Pulsating Masses
Neuro: Motor-Major Muscle Groups 5/5/Sensory-Gross Sensory Intact/Coordination-
Back: NT no CVAT
GU: Normal
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-No Edema/ROM/Pulses-CBR < 2 sec
Lymphatics: No LAD

Repeat/Additional Exams:
May 23 2011 6:25PM AHMED, ZAFAR - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

SYNCOPE AND COLLAPSE(780.2)
Likely from Cardio,myopathy, vs low glucose, needs Pacemaker check
AICD check

Congestive Heart Failure(428.0)
Acutre Systolic, follow up chest X ray and BNP
PT INR stat and at AM

SHORTNESS OF BREATH(786.05)
Likely secondary to CHF, r/out MI, check BNP, and Cardioplogy evaluation

Weakness (Nos)(780.79)
Weakness and Fatigue, likely from advanced Cardiomyopathy, has EF of 10%. Needs PT OT

Hypoglycemia in diabetic, unspecified(250.80)
Check Glucose, monitor off Insulin and oral agents.

Other Medical Orders/Additional Comments
Home Med Recon Continue - Aspirin 325 mg Tab, Daily
Home Med Recon Continue - Chlordiazepoxide 25 mg Cap, At Bedtime as needed
Home Med Recon Continue - Colace 100 mg Cap, Twice Daily as needed
Home Med Recon Continue - Colchicine 0.6 mg Tab, Twice A Day
Home Med Recon Continue - Coreg 25 mg Tab, Twice A Day

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Home Med Recon Continue - Glipizide 10 mg Tab, Twice A Day
Home Med Recon Continue - Lasix 80 mg Tab, Twice A Day
Home Med Recon Continue - Pepcid 20 mg Tab, Twice A Day
Home Med Recon Continue - Reglan 10 mg Tab, Three Times A Day
Home Med Recon Continue - Simvastatin 40 mg Tab, Daily
Home Med Recon Continue - Warfarin 5 mg Tab, Daily

Electronically signed and authenticated by the Following Physicians AHMED, ZAFAR Specialty Internal Medicine

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name KASON, THOMAS T Date of Note 05/24/2011 8:11 Note Type CONSULTATION

History / Subjective

HPI Paragraph: Patient with Pt c/o CHF Sx: PND,DOE,baseline SOB, leg edema. No recent syncope. No ICD shocks. No palps. No chest pain. Had cath in 2000 SFH: normal corns/LVEF=5%. Had ICD generator changed May 2010. Sees Dr. Tierney..
Other Notes: ECG: 100% electronic vent pacing.

Exam / Objective

Date/Time of Exam: May 24 2011 8:11AM
GA: Awake A&Ox3
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: JVD Mild
Lung/Chest Wall: Lungs-crackles L=R at bases/Chest Wall-Chest Wall NT
Cardio Vascular: RRR No M
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-No Pulsating Masses
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-Edema-Mild/ROM/Pulses-CBR < 2 sec

Repeat/Additional Exams:
May 24 2011 8:11AM KASON, THOMAS T - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

CHF - Acute on Chronic Systolic(N/A)
Needs IV diuresis. Would like to add an ACEI or ARB but her Cr is increasing. Need to watch CMP in AM. Continue coreg. BP too low 90/70 for hydralazine or imdur.

ICD(N/A)
Mgmt by Dr. Tierney. Agree with interrogation. Syncopal episode one week ago does not sound cardiac - but interrogation will tell if VT or VF involved.

Chronic coumadin use(N/A)
Interrogation confirms Afib and no shocks. So syncopal episode one week ago probably related to blood sugar.

NIDCM(N/A)
Normal corns by cath 2000 but LVEF=5% at that time. Has ICD.

DIABETES(648.03)
management per PCP

MITRAL VALVE DISORDER(424.0)
Moderate MR. Not a surgical candidate due to extremely low LVEF.

tricuspid regurg(N/A)
Mod to severe. Again, not an operative candidate.

HTN(401.9)
continue home meds.

Hyperlipidemia(272.4)
home meds.

Other Medical Orders/Additional Comments
Lasix 80mg IVP, , bid, 2 Day(s)
Hold PO lasix - we will use IV lasix

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

AM labs = CMP

Electronically signed and authenticated by the Following Physicians KASON, THOMAS T Specialty Cardiology

MD Name HARRIS, RICHARD G Date of Note 05/24/2011 9:53 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with remains hypoglycemic. Feels better though and denies any current SOB.
Other Notes:

Exam / Objective

Date/Time of Exam: May 24 2011 9:53AM
GA: Awake A&Ox3
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: NT Full ROM No JVD
Lung/Chest Wall: Lungs-Lungs CTA No Ret/Chest Wall-Chest Wall NT
Cardio Vascular: RRR No M
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-slightly distended
Neuro: Motor-Major Muscle Groups 5/5/Sensory-Gross Sensory Intact/Coordination-
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-No Edema/ROM/Pulses-CBR < 2 sec

Repeat/Additional Exams:
May 24 2011 9:53AM HARRIS, RICHARD G - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

Acute on Chronic Systolic Heart Failure with Severe Cardiomyopathy (EF 10%)(N/A)
continue IV Lasix. May need Dobutamine
HCCI consult
bmp in am

Weakness (Nos)(780.79)
PT and OT ordered

Hypoglycemia in diabetic, unspecified(250.80)
remains hypoglycemic
IVF: D5 0.9NS with 10meq kcl at 70cc/hr

Acute Renal Failure(N/A)
suspect due to prerenal azotemia/diuretic medications. May need nephrology consultation
consult Dr. Ventura

SYNCOPE AND COLLAPSE(780.2)
Likely from Cardio,myopathy, vs low glucose, needs Pacemaker check

Electronically signed and authenticated by the Following Physicians HARRIS, RICHARD G Specialty Internal Medicine

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name VENTURA, SALVATORE C Date of Note 05/24/2011 11:15 Note Type CONSULTATION

History / Subjective

HPI Paragraph: Patient with Consult Dictated.
Other Notes:

Exam / Objective

Assessment / Plan (Problem List)

Non-Oliguric Acute Renal Failure(N/A)
2nd to ischemic ATN; probably has chronic ischemic nephropathy. R/O diabetic nephropathy. Suggest dobutamine Rx. No indications for dialysis at this time.
Insert Foley
Urine analysis and urine culture
STAT Renal Ultrasound
Serum immunoelectrophoresis
Chem 7 at 6 PM today
Renal Panel tomorrow AM
Do renal ultrasound at bedside due to hypoglycemia
Hold colchicine: notify Dr. Harris

NIDCM/ICD/Parox A Fib/MR(N/A)
Start Dobutamine if OK with Dr. Kason

Hypoglycemia/NIDDM/Hyperlipidemia(N/A)
Stop Glipizide

H/O Hypertension(N/A)

Electronically signed and authenticated by the Following Physicians VENTURA, SALVATORE C Specialty Nephrology

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name SALVATORE C VENTURA Date of Note 05/24/2011 11:27 Note Type CONSULTATION

History / Subjective

CONSULTATION
Other Notes:
MetroSouth Medical Center
12935 South Gregory Street
Blue Island, Illinois 60406

CONSULTATION

[redacted] MR#: [redacted] ACCT#: [redacted]
DATE OF BIRTH: [redacted] DISCH:
PT: [redacted]

ADMIT DATE: 05/23/2011

CONSULTANT: SALVATORE VENTURA, M.D.

ATTENDING: ZAFAR AHMED, M.D.

DATE OF CONSULTATION: 05/24/2011

REASON FOR CONSULTATION: I am asked to see this patient by Dr. Harris for evaluation of elevated creatinine concentration.

HISTORY: [redacted] is a [redacted] woman with long-standing nonischemic dilated cardiomyopathy. She was admitted to MetroSouth Medical Center Hospital for evaluation of increasing abdominal girth, increasing leg swelling, and shortness of breath. Her symptoms were complicated by one episode of syncope one week prior to the admission. Upon admission, she was found to have severe hypoglycemia, and this is being corrected with adjustment of her diabetic medications and with administration of IV sugar.

[redacted] denies prior history of renal disease or nephrolithiasis. She does not have flank pain, gross hematuria, dysuria, nor urinary incontinence. However, review of computer records indicates that her creatine concentration measured between 1.3 and 1.5 mg/dL during the last year. It measured 1.33 mg/dL on 05/05/2011. Today, it measures 1.8 mg/dL.

PAST MEDICAL HISTORY:
1. Hypertension for 10 years.
2. Non-insulin-dependent diabetes mellitus for one year.
3. Hyperlipidemia.
4. ICD implant in 2000, replacement on 05/13/2010.
5. Paroxysmal atrial fibrillation.
6. Mitral regurgitation.
7. Nonischemic dilated cardiomyopathy complicated by congestive heart failure.

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MEDICATIONS: Lasix 80 mg IV b.i.d., Librium 25 p.o. q.h.s., colchicine 0.6 mg p.o. b.i.d., Coreg 25 mg p.o. b.i.d., Glucotrol 10 mg p.o. b.i.d., Pepcid 20 mg p.o. b.i.d., Reglan 10 mg p.o. t.i.d., Zocor 40 mg p.o. q.h.s., Colace 100 mg p.o. b.i.d., aspirin 325 mg p.o. daily, and Coumadin dose daily.

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12935 South Gregroy Street
Blue Island, Illinois 60406

CONSULTATION

[redacted] MR#: [redacted] ACCT#:

ALLERGIES: None.

SOCIAL HISTORY: The patient is married without children. The patient has a history of smoking cigarettes at a rate of one package per day between 14 and 52 years of age. She also reports drinking alcohol excessively between her teen years and 52 years of age. She does not abuse drugs.

FAMILY HISTORY: Mother is living and well. Father died of unknown cause. Two brothers and two sisters are living and well.

REVIEW OF SYSTEMS: The patient denies headache, recent acute change in vision, or hearing. She reports slurred speech during hypoglycemic episodes. She denies chest pain, chest pressure, or cough but does complain of orthopnea and paroxysmal nocturnal dyspnea. She becomes short of breath easily upon exertion. She denies nausea, vomiting, loss of appetite, abdominal pain, change in bowel habits, melena, or passage of blood per rectum. GU system is as described above. She complains of leg swelling.

PHYSICAL EXAMINATION:
General: The patient is alert, cooperative, in no distress, and sitting upright.
Vital Signs: She weighs 85.9 kg, temperature is 97.4, pulse is 72, blood pressure is 110/83, and respiratory rate is 24.
HEENT: Head is normocephalic. Both pupils are round and reactive to light. Extraocular movements are intact. Conjunctivae are pink. Mucous membranes of the oropharynx are moist.
Neck: Supple. Adenopathy is absent. Carotid pulses are weak but symmetrical. Bruits are absent.
Chest: Lung fields are remarkable for diminished air entry in both lower lobes.
Heart: Exam reveals S1, S2, and a 2/6 systolic murmur at the left sternal border. Pericardial rub is absent.
Breast: Examination is deferred.
Abdomen: Slightly distended and slight fullness is evident. Bowel sounds are present. The abdomen is soft and nontender. I do not

feel masses.
GU: Examination is deferred.
Rectal: Examination is deferred.
Extremities: Both lower extremities are edematous to the knees. The sacrum is edematous.
Neurologic: Examination is remarkable for the absence of asterixis.

LABORATORY TESTS: White blood count is 5.4, hemoglobin 14.7, potassium is 3.9, and albumin is 3.5.

IMPRESSION:
1. [redacted] has nonoliguric acute renal failure that is most

MetroSouth Medical Center
12935 South Gregroy Street
Blue Island, Illinois 60406

CONSULTATION

[redacted] MR#: [redacted] ACCT#:

likely secondary to ischemia-induced acute tubular necrosis. Causes of renal ischemia include hypotension and cardiomyopathy. I recommend dobutamine therapy if acceptable with Cardiology consultant. The patient also has a component of chronic ischemic nephropathy related to her heart disease. A workup to evaluate for possible diabetic nephropathy will be initiated. I recommend a Foley catheter, urinalysis and urine culture, renal ultrasound, and serum immunoelectrophoresis. Chemistries will be monitored. No acute indications for dialysis.
2. Nonischemic dilated cardiomyopathy, status post implantable cardioverter-defibrillator implant, paroxysmal atrial fibrillation and mitral regurgitation are being managed by HCCI. As discussed above, dobutamine therapy is suggested.
3. Hypoglycemia, superimposed on history of non-insulin-dependent diabetes mellitus and hyperlipidemia, is being managed by primary care physician. I recommend discontinuation of glipizide/Glucotrol.
5. History of hypertension in the past.

PLAN: As above.

Thank you. I will follow with you.

APPROVED ELECTRONICALLY BY
Salvatore C. Ventura, M.D. ON Wed May 25 15:55:44 CDT 2011

_____
SALVATORE VENTURA, M.D.

cc:AHMED, ZAFAR

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

VENTURA, SALVATORE

MT: V_DV_MST13
DD: 05/24/2011 11:27 AM
DT: 05/24/2011 09:25 PM
ID: 1231869
JOB: 97262

Exam / Objective

Assessment / Plan (Problem List)

Electronically signed and authenticated by the Following Physicians SALVATORE C VENTURA Specialty Nephrology

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

MD Name VENTURA, SALVATORE C Date of Note 05/25/2011 6:03 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with Evaluation of renal failure..
Other Notes: Urine output is good by foley. Mild SOB at rest. No chest pain. No N & V/abdominal pain.

Exam / Objective

Date/Time of Exam: May 25 2011 6:03AM
GA: Sitting upright in no distress. She is tachypneic
Lung/Chest Wall: Lungs-Diminished with crackles at both bases
Cardio Vascular: Paced, S1, S2. No rub
Abdomen: Palpation-Soft/BS-Good/Abd Appearance-Flank fullness
Neuro: Motor-No asterixis
Extremity: Location-Legs/Appearance-Edematous

Repeat/Additional Exams:
May 25 2011 6:03AM VENTURA, SALVATORE C - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

Non-Oliguric ARF 2nd Ischemic ATN(N/A)

Most likely has "chronic" ischemic nephropathy 2nd to cardiomyopathy. Urine analysis: 30 mg/dl protein. Urine Culture: pending. Renal Ultrasound: negative. [Creatinine] improved on dobutamine drip. Will stage the CKD with a 24 hour urine collection. She may need hemodialysis for fluid management: patient is aware.

Start 24 hour urine for creatinine clearance and protein.
Chem 7 at 5 PM today
Renal panel tomorrow AM

LVEF=10%/ICD/Parox A Fib/MR(N/A)

Very volume overloaded: pleural effusions, ascites and peripheral edema.
Stop IV fluids if OK with Dr. Harris
Double concentrate IV Dobutamine
Increase Lasix to 100 mg IV Q 8 hours

NIDDM/Hyperlipidemia(N/A)

Per PMD

Electronically signed and authenticated by the Following Physicians VENTURA, SALVATORE C Specialty Nephrology

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name FOCHESATTOFILLHO, LUCIANO Date of Note 05/25/2011 8:38 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with no New Complaints, alert and awake this am, having hypogycemic episodes still.
Other Notes:
Review of Systems NOT Covered in HPI:
All other systems reviewed and negative.,ENT: Neg,Heart: Neg,Resp: Neg,GI: Neg,GU: Neg,Skin: Neg,Neuro: Neg,Psych: Neg,Musculoskeletal: Neg,Endocrine: Neg,Hematologic/Lymphatic: Neg,Allergic/Immunologic: Neg,Constitutional Sxs: Neg,Eyes: Neg,

Exam / Objective

Date/Time of Exam: May 25 2011 8:38AM
GA: Awake A&Ox3
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: NT Full ROM +ve JVD
Lung/Chest Wall: Lungs-coarse, w decreased sounds bil in the lower fields/Chest Wall-Chest Wall NT
Cardio Vascular: RRR No M S3 S4 Rub
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-No Pulsating Masses distended w clear signs of ascites
Neuro: Motor-Major Muscle Groups 5/5/Sensory-Gross Sensory Intact/Coordination-
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-No Edema/ROM/Pulses-CBR < 2 sec

Repeat/Additional Exams:
May 25 2011 8:38AM FOCHESATTOFILLHO, LUCIANO - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

Acute on Chronic Systolic Heart Failure with Severe Cardiomyopathy (EF 10%)(N/A)
HCCI and renal on the case. Severly depressed EF w massive vol overload. On dobutamine (dose changed noted). Lasix increased by Dr Ventura. d/c IV fluids (switch D5 to D50 prn). Possible paracentesis (therapeutic) if discomfort increases even with appropriate diuresis (which I don't expect to have a significant effect on her ascites volume). Possibility of HD there as raised by Dr Ventura.

Acute Renal Failure(N/A)
previous Cr 1.2-1.38. US noted. Some kind of underlying CKD w superimposed ATN sec to extremely depressed EF, likely. CKD w/u by renal noted.

SYNCOPE AND COLLAPSE(780.2)
symptomatic hypoglycemia? Cont to have "sugar issues". D50 prn as above, accuchecks q 4 hrs. Awaiting interrogation to r/o ventricular event. HCCI on the case.

Hypoglycemia in diabetic, unspecified(250.80)
as above plus PO intake encouraged, Nursing staff to assist pt w feeding.

HTN(401.9)

Hypercholesterolemia(272.0)

DM(N/A)

Weakness (Nos)(780.79)
PT/OT.

Other Medical Orders/Additional Comments
accu Checks q 4 hrs
Nursing staff to assist pt w feeding.

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

cbc, cmp, magnesium, pt/ptt/inr in am
warfarin - pharmacy to dose, , N/A

Electronically signed and authenticated by the Following Physicians FOCHESATTOFILLHO, LUCIANO Specialty Internal Medicine

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name Milenkovic, Steven Robert/KASON, THOMAS T Date of Note 05/25/2011 9:13 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with Mildly sob just with conversation. States that she slept flat with 2 pillow last evening and woke up once with PND.
Other Notes:

Exam / Objective

Date/Time of Exam: May 25 2011 9:13AM
GA: Awake A&Ox3
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: NT Full ROM (+) JVD
Lung/Chest Wall: Lungs-Diminished bibasilar/Chest Wall-Chest Wall NT
Cardio Vascular: RRR 4/6 HSM
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-Distended
Neuro: Motor-Major Muscle Groups 5/5/Sensory-Gross Sensory Intact/Coordination-
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-+ Edema/ROM/Pulses-CBR < 2 sec

Repeat/Additional Exams:
May 25 2011 9:13AM Milenkovic, Steven Robert - Reviewed with Physician Assistant Agree with HPI PE Assessment and Plan

Assessment / Plan (Problem List)

CHF - Acute on Chronic Systolic(N/A)
Would like to add an ACEI or ARB but her Cr is increasing. Continue coreg. BP too low 90/70 for hydralazine or imdur. Would continue inotropic rx for another 24-48hrs. IV Lasix per Nephrology.
BNP in am.
appears euvolemic. Change dose of enalapril 10mg po bid
OK to DC home from cardiac standpoint. F/U with Dr. Erickson in 1 week, coumadin clinic in 1 week.
1.2liter/day fluid restriction at home

Normal Corns via Cath '00(N/A)

Severe MR(N/A)
Not a surgical candidate due to extremely low LVEF.

DIABETES(648.03)
management per PCP

HTN(401.9)
continue home meds.

Hyperlipidemia(272.4)
home meds.

ICD(N/A)
Mgmt by Dr. Tierney. Agree with interrogation. Syncopal episode one week ago does not sound cardiac - but interrogation will tell if VT or VF involved.

Chronic kidney disease(N/A)
Staging currently in progress.

Other Medical Orders/Additional Comments
Kdur 40MEq po x 1 now then 20mEq po daily
chem 6 in 1 week
D/C dobutamine

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

Prescriptions Provided to Patient
Potassium Chloride 20meq PO 1 tablet Daily 30 6

Electronically signed and authenticated by the Following Physicians Milenkovic, Steven Robert/KASON, THOMAS T Specialty Cardiology

MD Name VENTURA, SALVATORE C Date of Note 05/25/2011 14:46 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with Chart Review.
Other Notes:

Exam / Objective

Assessment / Plan (Problem List)

Non-Oliguric ARF 2nd Ischemic ATN(N/A)
Most likely has "chronic" ischemic nephropathy 2nd to cardiomyopathy. Urine Culture: pending. [Creatinine] improved. Await staging.

LVEF=10%/ICD/Parox A Fib/MR(N/A)

NIDDM/Hyperlipidemia(N/A)

Electronically signed and authenticated by the Following Physicians VENTURA, SALVATORE C Specialty Nephrology

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name VENTURA, SALVATORE C Date of Note 05/26/2011 6:20 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with Evaluation of renal failure.
Other Notes: Urine output is good in response to IV lasix. Patient is incontinent of urine at times. She denies SOB but still has increased abdominal girth/discomfort. She has severe leg swelling. No chest pain nor N & V.

Exam / Objective

Date/Time of Exam: May 26 2011 6:20AM
GA: Supine, no distress
Lung/Chest Wall: Lungs-Diminished at bases
Cardio Vascular: Paced, S1, S2. No rub
Abdomen: Palpation-Soft, nontender/BS-Good/Abd Appearance-Distended; flank fullness
Neuro: Motor-No asterixis
Extremity: Location-Legs/Appearance-Edematous

Repeat/Additional Exams:
May 26 2011 6:20AM VENTURA, SALVATORE C - Reviewed pertinent diagnostic tests, vital signs, and clinical notes

Assessment / Plan (Problem List)

Non-Oliguric ARF/CKD 2nd Ischemic Nephropathy(N/A)

[Creatinine] improved to 1.62 mg/dl with supportive care. Patient refuses foley and she is incontinent of urine: unable to stage her CKD. Dialysis for Rx of cardiomyopathy complicated by renal failure and refractory, severe fluid retention was discussed with patient. She does not wish to consider dialysis as a treatment option at this time. I will sign off case.

Remove patient name from Dr. Ventura's list.

LVEF=10%/ICD/Parox A Fib/MR(N/A)

Medical managment per HCCI.

NIDDM/Hyperlipidemia(N/A)

Per PMD

Electronically signed and authenticated by the Following Physicians VENTURA, SALVATORE C Specialty Nephrology

Metro South Medical Center 12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name Milenkovic, Steven Robert/KASON, THOMAS T Date of Note 05/26/2011 9:10 Note Type PROGRESS NOTE

History / Subjective

HPI Paragraph: Patient with Still looks volume overloaded but denies sob/orthopnea.
Other Notes:

Exam / Objective

Date/Time of Exam: May 26 2011 9:10AM
GA: Awake A&Ox3
Skin: No pallor/ rashes warm & moist
HEENT: PERRL EOMI Moist Mucous Membranes No Icterus
Neck: NT Full ROM No JVD
Lung/Chest Wall: Lungs-Crackles bibasilar/Chest Wall-Chest Wall NT
Cardio Vascular: RRR 3/6 HSM
Abdomen: Palpation-Tenderness-None/BS-BS-NL/No Bruits/Abd Appearance-No Pulsating Masses
Neuro: Motor-Major Muscle Groups 5/5/Sensory-Gross Sensory Intact/Coordination-
Extremity: Location-Low Ext Bilateral/Pain-Tenderness-None/Sub Location-/Appearance-No Edema/ROM/Pulses-CBR < 2 sec

Repeat/Additional Exams:
May 26 2011 9:10AM Milenkovic, Steven Robert - Reviewed with Physician Assistant Agree with HPI PE Assessment and Plan

Assessment / Plan (Problem List)

CHF - Acute on Chronic Systolic(N/A)
Would like to add an ACEI or ARB but her Cr is increasing. Continue coreg. BP too low 90/70 for hydralazine or imdur. IV Lasix per Nephrology.
Chem 6 and BNP in am.
D/C IV Lasix after pm dose and restart 80mg po BID in am of 5/27.

Normal Corns via Cath '00(N/A)

DIABETES(648.03)
management per PCP

Severe MR(N/A)
Not a surgical candidate due to extremely low LVEF.

HTN(401.9)
continue home meds.

Hyperlipidemia(272.4)
home meds.

ICD(N/A)
Mgmt by Dr. Tierney. Agree with interrogation. Syncopal episode one week ago does not sound cardiac - but interrogation will tell if VT or VF involved.

Chronic kidney disease(N/A)
Staging currently in progress.

Electronically signed and authenticated by the Following Physicians Milenkovic, Steven Robert/KASON, THOMAS T Specialty Cardiology

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

MD Name FOCHESATTOFILLHO, LUCIANO Date of Note 05/26/2011 9:25 Note Type DISCHARGE

History / Subjective

DISCHARGE SUMMARY
Other Notes: Admit Date: 5/23/2011 3:33:00 PM
Discharge Date: Patient Not Yet Discharged

Discharge Diagnosis
Acute on Chronic Systolic Heart Failure with Severe Cardiomyopathy (EF 10%)
AICD in place
PAF
ECHO EF 10% and severe MR
ARF/CKD - Cr at discharge ~ 1.55
HTN
Hypercholesterolemia
DM
Hypoglycemia in diabetic, unspecified

Procedures

Consultants/Specialty
VENTURA,SALVATORE C : Nephrology
AHMED,ZAFAR : Internal Medicine
KASON,THOMAS T : Cardiology
HARRIS,RICHARD G : Internal Medicine
Milenkovic,Steven Robert : Cardiology
FOCHESATTOFILLHO,LUCIANO : Internal Medicine

Discharge Diet
Cardiac Diet : Renal Diet : 1800 Calorie ADA Diet

Dicharge Activity
Activity As Tolerated

Additional Discharge Instructions
Click here to add instructions : CHF - Patient was given instruction on diet, exercise, weight monitoring, activity level, follow up and what to do if symptoms worsen.

Follow Up MDs
AHMED, ZAFAR NULL 12:00:00 AM IN 1 WEEK
Erickson, Kurt W, M.D. 2338 New Street NULL Blue Island IL 60406 (708) 824-1114 12:00:00 AM IN 2 WEEKS

Patient Medication List
Aspirin 325 mg Tab, 1 tablet, Daily
Colace 100 mg Cap, 1 tablet, Twice Daily as needed
Coreg 25 mg Tab, 1 tablet, Twice A Day
DOCUSATE SODIUM, 100 MG, 2x a day as needed
Enalapril 10mg PO, 1 tablet, Twice A Day, starting taking in 1 week
FAMOTIDINE, 20 MG, 2 times a day 0900,2100
HUMALOG 6units After Meals Subcutaneous, 6 UNITS, Three times daily AFTER Meals
Insulin Detemir SubQ, 20 units, At Bedtime
Lasix Oral, 100 mg, Twice A Day
Potassium Chloride 20meq PO, 1 tablet, Daily
Reglan 10 mg Tab, Three Times A Day
Simvastatin 40 mg Tab, Daily

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

Warfarin 5 mg Tab, Daily
ZALEPLON, 10 MG, at bedtime as need 2100

Exam / Objective

Assessment / Plan (Problem List)

Electronically signed and authenticated by the Following Physicians FOCHESATTOFILLHO, LUCIANO Specialty Internal Medicine

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Diagnostic Results

Ordering Staff	Date/Time Resulted	Diagnostic Name	Result Interpretation	Reviewed By	Date/Time Reviewed
AHMED, ZAFAR	05/23 16:28	Glucose monitor	BGM-194		
AHMED, ZAFAR	05/23 19:01	XR CHEST ONE VIEW PORTABLE			
AHMED, ZAFAR	05/24 5:00	VITAMIN B12			
AHMED, ZAFAR	05/24 5:00	FOLATE			
AHMED, ZAFAR	05/23 18:51	CBC W AUTO DIFF		KASON, THOMAS T	05/24 8:18
AHMED, ZAFAR	05/23 18:51	PT	INT-2.80,PT-31.6	McCabe, RN, Janet	05/23 21:54
AHMED, ZAFAR	05/23 18:51	COMPREHENSIVE METABOLIC PANEL	NA-144,K-3.9,CL-108,CO2-23,BUN-49,CREAT-1.80,GLUCOSE-44,AGAP-13,AG RATIO-0.9,BUNCR-27,GLOBTOT-4.1,ALB-3.5,TPROT-7.6,CA-9.4,ALT-<16,AST-40,ALKPHOS-57,GFR-36.7,TBILI-1.6	KASON, THOMAS T	05/24 8:22
AHMED, ZAFAR	05/23 18:52	CK + CKMB	CK1-147	McCabe, RN, Janet	05/23 21:46
AHMED, ZAFAR	05/23 19:10	CKMB	MBINDEX-4.1,CKMB-6	McCabe, RN, Janet	05/23 21:46
AHMED, ZAFAR	05/23 18:52	TROPONIN I	TROPU-0.10	McCabe, RN, Janet	05/23 21:46
AHMED, ZAFAR	05/23 19:26	CBC W AUTO DIFF	WBC-5.5,RBC-5.63,HGB-15.9,HCT-48.5,PLTCT-183,MCV-86.2,MCHC-32.7,RBCMORPH-Slight Anisocytosis Microcytosis Macrocytosis Poikilocytosis Target Cells,MANDIFFDONE-Man diff not indicated,BASOS-0.3,EO-0.9,MONOS1-9.4,LYMPH-18.9,NEUTRO-70.5,MPV-9.1,RDW-21.3,MCH-28.2	Critchett, RN, Daisyrenee	05/24 8:26
	05/23 22:46	EKG - Preliminary			
AHMED, ZAFAR	05/23 21:07	Glucose monitor	BGM-94		
AHMED, ZAFAR	05/24 2:52	CK + CKMB	CK1-164		
AHMED, ZAFAR	05/24 3:06	CKMB	MBINDEX-4.3,CKMB-7		
AHMED, ZAFAR	05/24 2:52	TROPONIN I	TROPU-0.10	KASON, THOMAS T	05/24 8:00
AHMED, ZAFAR	05/24 5:00	PT	INT-2.60,PT-29.3		
AHMED, ZAFAR	05/24 5:00	COMPREHENSIVE METABOLIC PANEL	NA-CANCELED,K-CANCELED,CL-CANCELED,CO2-CANCELED,BUN-CANCELED,CREAT-CANCELED,GLUCOSE-CANCELED,AGAP-CANCELED,AG RATIO-CANCELED,BUNCR-CANCELED,GLOBTOT-CANCELED,ALB-CANCELED,TPROT-CANCELED,CA-CANCELED,ALT-CANCELED,AST-CANCELED,ALKPHOS-CANCELED,GFR-CANCELED,TBILI-CANCELED		
AHMED, ZAFAR	05/24 5:00	VITAMIN B12 FOLATE		KASON, THOMAS T	05/24 8:12
AHMED, ZAFAR	05/24 5:00	CBC W AUTO DIFF	WBC-5.4,RBC-5.26,HGB-14.7,HCT-44.8,PLTCT-182,MCV-85.1,MCHC-32.7,RBCMORPH-Few Anisocytosis; Slight Poikilocytosis Ovalocytes Target Cells Burr Cells,MONOS-14,LYMPHS-15,BANDS-2,SEGS-69,MANDIFFDONE-Man Diff Done,MPV-9.5,RDW-21.2,MCH-27.9		
AHMED, ZAFAR	05/23 18:51	TSH	TSH-2.078	Blazek, RN, Patricia Marie	05/24 13:51

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

UNKNOWN, PHYSICIAN	05/23 20:17	VIRTUAL RADIOLOGIC PRELIM REPO	History:Progressively worsening functional status, episode of syncope 1 week ago, weakness/fatigue. H/o aicd, cardiomyopathy, hypercholeserolemia, diabetes, bronchitis, chf, htn Technique: Axial images from a CT study of the brain were performed without IV contrast. No prior study. Findings: Mild age -related cerebral and cerebellar atrophy. Minor chronic small vessel ischemic disease in the periventricular white matter. Bilateral basal ganglia calcifications. No acute intracranial hemorrhage. No mass effect, midline shift or sulcal effacement. Ventricular system and cisternal spaces are unremarkable. Imaged mastoid air cells and paranasal sinuses are clear. No acute calvarial fracture. Impression: Atrophy and chronic small vessel ischemic disease changes, as outlined above. No acute intracranial hemorrhage. No CT evidence of acute ischemic change.	McCabe, RN, Janet	05/24 1:41
AHMED, ZAFAR	05/24 10:52	CK + CKMB	CK1-133	KASON, THOMAS T	05/24 8:12
HARRIS, RICHARD G	05/24 7:48	B-TYPE NATRIURETIC PEPTIDE	BNP-2444	KASON, THOMAS T	05/24 8:12
AHMED, ZAFAR	05/24 6:31	COMPREHENSIVE METABOLIC PANEL	NA-145,K-4.1,CL-107,CO2-27,BUN-51,CREAT-1.88,GLUCOSE-53,AGAP-11,AG RATIO-0.9,BUNCR-27,GLOBTOT-3.9,ALB-3.4,TPROT-7.3,CA-9.1,ALT-18,AST-41,ALKPHOS-55,GFR-34.9,TBILI-1.5	Critchett, RN, Daisyrenee	05/24 15:26
AHMED, ZAFAR	05/24 6:32	VITAMIN B12 FOLATE	FOLATE-14.6,B12-1894	KASON, THOMAS T	05/24 8:12
AHMED, ZAFAR	05/24 1:21	Glucose monitor	BGM-71		
AHMED, ZAFAR	05/24 5:47	Glucose monitor	BGM-68		
AHMED, ZAFAR	05/24 9:42	Glucose monitor	BGM-54		
AHMED, ZAFAR	05/24 11:18	Glucose monitor	BGM-70		
AHMED, ZAFAR	05/24 10:18	CKMB	MBINDEX-4.5,CKMB-6		
AHMED, ZAFAR	05/24 5:00	HEMOGLOBIN A1C	HA1C-7.1		

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

AHMED, ZAFAR	05/23 19:01	XR CHEST 2 VIEWS	HARRIS, RICHARD G	05/24 9:53

CHEST, TWO VIEWS:
ACCESSION: 0142076
CLINICAL INDICATION: Shortness of breath. Congestive failure.
COMPARISON: One view chest 05/06/2011.
TECHNIQUE: AP and lateral upright two view chest, 1955 hours, 05/23/2011.
FINDINGS: Heart size is moderately increased with multichamber enlargement.
The aorta is tortuous and calcified. A left ICD seen with right atrial and
right ventricular leads. Heart size is moderately increased. Hazy opacity at
the right costophrenic angle and at the left base as well as blunting of the
posterior left costophrenic angle indicates bilateral pleural effusions with
subjacent airspace disease such as atelectasis, infiltrate, or basilar
congestive change. Left hemidiaphragm is indistinct on the lateral and frontal
view. The mid and upper lungs are essentially clear.
IMPRESSION: BIBASILAR PLEURAL EFFUSIONS AND SUBJACENT ATELECTASIS OR
INFILTRATE OR BASILAR CONGESTIVE CHANGE. MODERATE CARDIOMEGALY. LEFT ICD WITH
RIGHT ATRIAL AND RIGHT VENTRICULAR LEADS. APPEARANCE IS SIMILAR TO THE
PREVIOUS EXAMINATION OF 05/06/2011.

_____
Harry R. Platt, M.D.
APPROVED ELECTRONICALLY BY
Harry R. Platt, M.D. ON Tue May 24 13:04:14 CDT 2011

cc:AHMED, ZAFAR
PLATT, HARRY
MT: ASR
DD: 05/24/2011 08:17 AM
DT: 05/24/2011 09:54 AM
ID: 1231783
JOB: 1231783

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

AHMED, ZAFAR	05/23 19:01	CT BRAIN W/O IV CONTRAST	CT SCAN OF THE BRAIN WITHOUT IV CONTRAST: ACCESSION: 0142077 CLINICAL INDICATION: Shortness of breath. Syncope. Worsening functional status for 1 week. Weakness and fatigue. Cardiomyopathy. ICD. Diabetes. Bronchitis. Congestive failure. Hypertension. FINDINGS: Mild prominence of the cortical sulci are noted. There are physiologic calcifications in the basal ganglia. Mild low attenuation white matter changes suggest minimal small vessel white matter chronic ischemia including the basal ganglia regions. There are calcifications in the carotid siphons and vertebral arteries. Bone window settings appear normal. IMPRESSION: MINIMAL SMALL VESSEL WHITE MATTER CHRONIC ISCHEMIC CHANGE. NO HEMORRHAGE OR OTHER FOCAL INTRACRANIAL LESIONS SEEN OTHERWISE. (PQRI: CT WITHIN 24 HOURS OF PRESENTATION. NO HEMORRHAGE, ACUTE INFARCTION, OR ABNORMAL MASS ON THIS STUDY). _____ Harry R. Platt, M.D. APPROVED ELECTRONICALLY BY Harry R. Platt, M.D. ON Tue May 24 13:08:54 CDT 2011 cc:AHMED, ZAFAR PLATT, HARRY MT: ASR DD: 05/24/2011 08:58 AM DT: 05/24/2011 10:02 AM ID: 1231794 JOB: 1231794	McCabe, RN, Janet	05/24 1:41
AHMED, ZAFAR	05/24 5:03	Glucose monitor	BGM-62		
VENTURA, SALVATORE C	05/24 14:04	URINALYSIS ROUTINE AUTO	HYALINE-21-50,MUCUSURINE-OCCASSIONAL,EPITHLIAL-11-20,WBC.-0-3,RBC.-0-3,LEUKOURINE-NEG,UROBILURINE-NORMAL,NITRITE-NEG,UBLD-TRACE,BILIURINE-NEG,KETURINE-NEG,UGLUC-NEG,PROTEINUA-30,PHURINE-5.0,SPCGRAVITY-1.007,CHARACTER-CLEAR,COLORURINE-YELLOW	Bayless, RN, Michel	05/24 15:06
AHMED, ZAFAR	05/24 14:42	Glucose monitor	BGM-107		
AHMED, ZAFAR	05/24 16:05	Glucose monitor	BGM-108		

Metro South Medical Center

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

VENTURA, SALVATORE C	05/24 11:23	US RETROPERI KIDNEY/BLADDER	ULTRASOUND OF THE RETROPERITONEUM, KIDNEY, BLADDER: ACCESSION: 0142219 HISTORY: BUN 51, creatinine 1.88. COMPARISON STUDY: None. FINDINGS: The right kidney measures around 10.5 cm in length x 4.6 x 4.3 cm in diameter. The left kidney measures around 10.0 cm in length x 4.8 x 4.1 cm in diameter. There is no hydronephrosis or mass of either kidney. Renal parenchyma is preserved. There is free fluid in the abdomen. Foley catheter is present in the bladder which cannot be otherwise evaluated. IMPRESSION: 1. NO MASS OR HYDRONEPHROSIS OF EITHER KIDNEY. NO ACUTE RENAL ABNORMALITIES. ASSESSMENT OF PARENCHYMAL ECHOGENICITY IS SOMEWHAT LIMITED ON THE RIGHT WITH QUESTION OF SLIGHT INCREASED ECHOGENICITY. THE LEFT RENAL ECHOGENICITY APPEARS NORMAL. 2. ASCITES IN FOUR QUADRANTS. _____ Liisa L. Laakso, D.O. APPROVED ELECTRONICALLY BY Liisa L. Laakso, D.O. ON Tue May 24 17:40:40 CDT 2011 cc:LAAKSO, LIISA MT: ASR DD: 05/24/2011 04:20 PM DT: 05/24/2011 05:24 PM ID: 1232037 JOB: 1232037	Critchett, RN, Daisyrenee	05/24 18:58
AHMED, ZAFAR	05/24 18:52	CK + CKMB	CK1-121		
VENTURA, SALVATORE C	05/24 18:00	RENAL FUNCTION PANEL	NA-144,K-3.9,CL-108,CO2-25,BUN-49,CREAT-1.75,GLUCOSE-57,AGAP-11,BUNCR-28,CA-9.3,PHOS-5.4,ALB-3.5,GFR-37.9	VENTURA, SALVATORE C	05/25 6:03
AHMED, ZAFAR	05/24 20:44	Glucose monitor	BGM-64		
AHMED, ZAFAR	05/25 3:16	Glucose monitor	BGM-153		
AHMED, ZAFAR	05/25 5:33	Glucose monitor	BGM-117		
*HCCI-CARDIOLOGISTS	05/25 5:00	COMPREHENSIVE METABOLIC PANEL			
VENTURA, SALVATORE C	05/25 5:00	PHOSPHOROUS			
VENTURA, SALVATORE C	05/25 5:00	IFE PANEL	IFEINT-CANCELED,SPEINTERPT-CANCELED,IGM-CANCELED,IGA-CANCELED,IG_G-CANCELED,GAMMA-CANCELED,BETA-CANCELED,ALPHA2-CANCELED,ALPHA1-CANCELED,ALB-CANCELED,TPROT-CANCELED		
AHMED, ZAFAR	05/24 22:02	Glucose monitor	BGM-68		
AHMED, ZAFAR	05/24 22:59	Glucose monitor	BGM-140		
*HCCI-CARDIOLOGISTS	05/25 7:30	COMPREHENSIVE METABOLIC PANEL	NA-146,K-3.6,CL-108,CO2-25,BUN-47,CREAT-1.67,GLUCOSE-99,AGAP-13,AG RATIO-1.0,BUNCR-28,GLOBTOT-3.6,ALB-3.6,TPROT-7.2,CA-9.1,ALT-21,AST-35,ALKPHOS-64,GFR-40.0,TBILI-1.5		
VENTURA, SALVATORE C	05/25 7:30	PHOSPHOROUS	PHOS-5.0		
	05/25 9:10	EKG - Preliminary			
VENTURA, SALVATORE C	05/26 5:00	RENAL FUNCTION PANEL			
FOCHESATTOFILLHO, LUCIANO	05/25 9:48	PT	INT-3.19,PT-36.1		

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

VENTURA, SALVATORE C	05/25 7:31	IFE PANEL	PATHREVIEW-Reviewed and approved by Dr. A. Handelsman, Pathologist,IFEINT-No monoclonal proteins identified.,SPEINTERPT-Serum Protein Electrophoresis shows an essentially normal electophoretic pattern.,IGM-63,IGA-262,IG_G-1810,GAMMA-1.65,BETA-0.82,ALPHA2-0.73,ALPHA1-0.27,ALB-3.33,TPROT-6.8		
VENTURA, SALVATORE C	05/25 17:00	BASIC METABOLIC PNL (CA TOTAL)	NA-142,K-4.1,CL-107,CO2-25,BUN-48,CREAT-1.62,GLUCOSE-189,GFR-41.4,AGAP-10,BUNCR-30,CA-8.7		
AHMED, ZAFAR	05/25 11:06	Glucose monitor	BGM-115		
AHMED, ZAFAR	05/25 16:29	Glucose monitor	BGM-291		
AHMED, ZAFAR	05/25 21:09	Glucose monitor	BGM-193		
FOCHESATTOFILLHO, LUCIANO	05/26 5:00	MAGNESIUM	MAG-1.5		
FOCHESATTOFILLHO, LUCIANO	05/26 5:00	PHOSPHOROUS	PHOS-4.3		
FOCHESATTOFILLHO, LUCIANO	05/26 5:00	COMPREHENSIVE METABOLIC PANEL	NA-146,K-4.1,CL-109,CO2-24,BUN-46,CREAT-1.55,GLUCOSE-131,AGAP-13,AG RATIO-0.9,BUNCR-30,GLOBTOT-3.6,ALB-3.1,TPROT-6.7,CA-8.8,ALT-18,AST-33,ALKPHOS-54,GFR-43.6,TBILI-1.4	Blazek, RN, Patricia Marie	05/26 8:50
*HCCI-CARDIOLOGISTS	05/26 5:00	B-TYPE NATRIURETIC PEPTIDE	BNP-1429	Milenkovic, Steven Robert	05/26 9:04
FOCHESATTOFILLHO, LUCIANO	05/26 5:00	PT PTT	PTT-42.0,INT-3.30,PT-37.8		
FOCHESATTOFILLHO, LUCIANO	05/26 5:00	CBC W AUTO DIFF	WBC-4.7,RBC-5.24,HGB-15.0,HCT-45.3,PLTCT-146,MCV-86.5,MCHC-33.1,COMMENT10-slt enlarged plt,RBCMORPH-Slight Anisocytosis Polychromasia Poikilocytosis Burr Cells Spherocyte Target Cells Schistocytes,MANDIFFDONE-Man diff not indicated,BASOS-0.3,EO-2.4,MONOS1-10.3,LYMPH-20.1,NEUTRO-66.9,MPV-9.5,RDW-21.8,MCH-28.6	Blazek, RN, Patricia Marie	05/26 8:50
VENTURA, SALVATORE C	05/24 14:04	CULTURE URINE	Specimen: Urine Cath Collected: 05/24/2011 14:00 Status: Final Last Updated: 05/26/2011 11:33 Culture Result (Final) Colony Count <10,000 COL/ML Isolate 1 (Final) Streptococcus agalactiae (Group B)		
AHMED, ZAFAR	05/26 11:24	Glucose monitor	BGM-186		
MILENKOVIC, STEVEN	05/27 5:00	BUN			
MILENKOVIC, STEVEN	05/27 5:00	LYTES (NA K CL CO2)			
MILENKOVIC, STEVEN	05/27 5:00	B-TYPE NATRIURETIC PEPTIDE			
MILENKOVIC, STEVEN	05/27 5:00	CREATININE			
FOCHESATTOFILLHO, LUCIANO	05/27 5:00	PT	INT-CANCELED,PT-CANCELED		

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Medical Orders

MD Name	MD Time	Medical Orders	Clinical Staff	Clinical Staff Time	Order Status
		micu standing orders Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:31	Secretary Completed
		CRITICAL CARE/TELEMETRY ADMISSION ORDER SET per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		MEDICATION ORDERS per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Acetaminophen 650mg oral every 4 hours as needed for fever more than 101 degrees F or pain - notify physician if no relief in 1 hour per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Colace 100mg oral as needed at bedtime for constipation per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Milk of magnesia 30ml oral as needed for constipation per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Mylanta 30ml oral as needed for indigestion per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Nitroglycerin gr1/150 sublingual as needed - may repeat x 3 every 5 minutes if systolic BP more than 90 per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Sonata 10mg oral as needed at bedtime for sleep if under age 65 and over 50kg reduce dose to 5mg if over 65 or under 50kg per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Tigan 200mg Intramuscular every 6 hours as needed for nausea per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		GENERAL NURSING ORDERS per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Obtain vascular access with PIVL and flush per protocol per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Daily weight every morning and record per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Oxygen at 2l/minute - titrate as needed per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Record Intake and output every shift per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Bedrest with BRP per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Continuous Cardiac Monitor per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Notify Physician if no relief after first 2 doses of NTG for acute chest pain per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Institute ACLS Protocols for sustained symptomatic arrhythmias per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Notify physician of all arrhythmia events, actions and current status as soon as possible per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Initiate Potassium and Magnesium replacement protocols as needed per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		DIET per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		DIAGNOSTIC TESTING per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Repeat Troponin level 8 hours after first draw x 1 per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		Repeat CK-MB level every 8 hours after first draw x 2 per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		PCXR STAT if not done in ED per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		12 lead EKG - STAT if not done in ED per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed
		12 lead EKG daily x 2 per AHMED, ZAFAR MD	Bayless, RN, Michel	05/23 18:37	Secretary Completed

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

		cbc, cmp, tsh, ua, urcl, trop, cpk, STAT Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:39	Secretary Completed
		HGB A1C, VIT B12, FOLIC, CBC, CMP IN AM Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:41	Secretary Completed
		CPK AND TROP Q8HRS Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:42	Secretary Completed
		Brain CT WITHOUT contrast STAT Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:42	Secretary Completed
		Chest X-ray PA/lateral STAT Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:42	Secretary Completed
		PT/OT TO CONSULT WHEN CLEARED BY CARDIOLOGY Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:43	Secretary Completed
		HOLD ALL DIABETIC MEDICATIONS UNTIL NOTIFIED BY Z AHMED Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:43	Secretary Completed
		HOLD LOW DOSE SLIDING SCALE UNTIL PATIENTS BLOOD SUGAR IS GREATER THAN 150 Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:44	Secretary Completed
		Renal Diet Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:44	Secretary Completed
		CONSULT Dr. IAFFALDANO Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:45	Secretary Completed
		Acc Check QID Phone order written/repeated/verified per AHMED, ZAFAR	Bayless, RN, Michel	05/23 18:47	Secretary Completed
		Admit to Telemetry Unit per AHMED, ZAFAR MD	Burge, RN, Patricia	05/23 19:03	Secretary Completed
		Initiate MICU order set per AHMED, ZAFAR MD	Burge, RN, Patricia	05/23 19:03	Secretary Completed
		Initiate electrolyte replacement order set per AHMED, ZAFAR MD	Burge, RN, Patricia	05/23 19:03	Secretary Completed
		Change diet from renall to diabetic Phone order written/repeated/verified per AHMED, ZAFAR	Critchett, RN, Daisyrenee	05/24 7:07	Secretary Completed
		dc iv fliuds; order # 23 from Mar Phone order written/repeated/verified per REYNOLDS, ALBERT	Bahena, RN, Cecilia	05/26 3:52	Secretary Completed
		no coumadin today Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Kane Rph, Richard	05/26 11:59	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:40	AICD check	Bayless, RN, Michel	05/23 18:58	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Aspirin 325 mg Tab, Daily	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Chlordiazepoxide 25 mg Cap, At Bedtime as needed	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Colace 100 mg Cap, Twice Daily as needed	Bayless, RN, Michel	05/23 18:48	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Colchicine 0.6 mg Tab, Twice A Day	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Coreg 25 mg Tab, Twice A Day	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:42	Home Med Recon Continue - Glipizide 10 mg Tab, Twice A Day	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:43	Home Med Recon Continue - Lasix 80 mg Tab, Twice A Day	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:43	Home Med Recon Continue - Pepcid 20 mg Tab, Twice A Day	Bayless, RN, Michel	05/23 18:48	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:43	Home Med Recon Continue - Reglan 10 mg Tab, Three Times A Day	Bayless, RN, Michel	05/23 18:49	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:43	Home Med Recon Continue - Simvastatin 40 mg Tab, Daily	Bayless, RN, Michel	05/23 18:48	Secretary Completed

Metro South Medical Center

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[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

AHMED, ZAFAR	05/23/2011 18:43	Home Med Recon Continue - Warfarin 5 mg Tab, Daily	Bayless, RN, Michel	05/23 18:48	Secretary Completed
AHMED, ZAFAR	05/23/2011 18:46	PT INR stat and at AM	Bayless, RN, Michel	05/23 18:49	Secretary Completed
HARRIS, RICHARD G	05/24/2011 7:45	bnp level now	Bayless, RN, Michel	05/24 8:15	Secretary Completed
KASON, THOMAS T	05/24/2011 8:19	Lasix 80mg IVP, , bid, 2 Day(s)	Bayless, RN, Michel	05/24 8:36	Secretary Completed
KASON, THOMAS T	05/24/2011 8:20	Hold PO lasix - we will use IV lasix	Bayless, RN, Michel	05/24 8:36	Secretary Completed
KASON, THOMAS T	05/24/2011 8:20	AM labs = CMP	Bayless, RN, Michel	05/24 8:36	Secretary Completed
HARRIS, RICHARD G	05/24/2011 9:55	HCCI consult	Critchett, RN, Daisyrenee	05/24 10:23	Secretary Completed
HARRIS, RICHARD G	05/24/2011 9:55	bmp in am	Bayless, RN, Michel	05/24 10:22	Secretary Completed
HARRIS, RICHARD G	05/24/2011 9:57	consult Dr. Ventura	Critchett, RN, Daisyrenee	05/24 10:03	RN Completed
HARRIS, RICHARD G	05/24/2011 9:58	IVF: D5 0.9NS with 10meq kcl at 70cc/hr	Critchett, RN, Daisyrenee	05/24 10:03	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:16	Insert Foley	Bayless, RN, Michel	05/24 12:15	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:16	Urine analysis and urine culture	Bayless, RN, Michel	05/24 11:41	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:16	STAT Renal Ultrasound	Bayless, RN, Michel	05/24 12:15	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:17	Serum immunoelectrophoresis	Bayless, RN, Michel	05/24 11:40	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:17	Chem 7 at 6 PM today	Bayless, RN, Michel	05/24 11:40	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:17	Renal Panel tomorrow AM	Bayless, RN, Michel	05/24 11:40	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:18	Start Dobutamine if OK with Dr. Kason	Bayless, RN, Michel	05/24 12:15	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:18	Do renal ultrasound at bedside due to hypoglycemia	Bayless, RN, Michel	05/24 12:15	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:25	Stop Glipizide	Bayless, RN, Michel	05/24 11:40	Secretary Completed
VENTURA, SALVATORE C	05/24/2011 11:26	Hold colchicine: notify Dr. Harris	Bayless, RN, Michel	05/24 11:40	Secretary Completed
KASON, THOMAS T	05/24/2011 12:14	OK to start Dobutamine at 5mcg/kg/min Phone order written/repeated/verified per KASON, THOMAS T	Critchett, RN, Daisyrenee	05/24 12:14	Secretary Completed
HARRIS, RICHARD G	05/24/2011 13:55	Inpatient status from the start Phone order written/repeated/verified per HARRIS, RICHARD G	Blazek, RN, Patricia Marie	05/24 13:55	Secretary Completed
AMIN, PARAG K	05/24/2011 22:11	D50 ivp x1 stat Phone order written/repeated/verified per AMIN, PARAG K	Bahena, RN, Cecilia	05/24 22:11	RN Completed
VENTURA, SALVATORE C	05/25/2011 6:07	Start 24 hour urine for creatinine clearance and protein.	Bahena, RN, Cecilia	05/25 6:51	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 6:07	Chem 7 at 5 PM today	Bahena, RN, Cecilia	05/25 6:51	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 6:07	Renal panel tomorrow AM	Bahena, RN, Cecilia	05/25 6:51	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 6:08	Stop IV fluids if OK with Dr. Harris	Bahena, RN, Cecilia	05/25 6:51	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 6:09	Double concentrate IV Dobutamine	Bahena, RN, Cecilia	05/25 6:50	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 6:09	Increase Lasix to 100 mg IV Q 8 hours	Bahena, RN, Cecilia	05/25 6:51	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 6:34	change accucheck Q4hours Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Bahena, RN, Cecilia	05/25 6:34	Secretary Completed

Metro South Medical Center

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

FOCHESATTOFILLHO, LUCIANO	05/25/2011 6:39	give one amp of d50 ivp now Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Bahena, RN, Cecilia	05/25 6:39	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 6:39	stop iv fluids Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Bahena, RN, Cecilia	05/25 6:39	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 6:40	call for blood sugar below 80 Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Bahena, RN, Cecilia	05/25 6:40	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 8:46	accu Checks q 4 hrs	White, RN, Carina	05/25 8:55	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 8:55	Nursing staff to assist pt w feeding.	White, RN, Carina	05/25 8:55	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 9:02	cbc, cmp, magnesium, pt/ptt/inr in am	White, RN, Carina	05/25 9:26	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 9:03	warfarin - pharmacy to dose, , N/A	White, RN, Carina	05/25 9:26	Secretary Completed
Milenkovic, Steven Robert	05/25/2011 9:15	BNP in am.	White, RN, Carina	05/25 9:26	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 9:30	Pt/INR now & daily am while on coumadin per coumadin phcy protocol Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Kannankeril, Jaya J.	05/25 9:30	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 11:09	No COUMADIN today per coumadin phcy protocol Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	Kannankeril, Jaya J.	05/25 11:09	Secretary Completed
SHIN, HENRY	05/25/2011 11:28	appears euvolemic. Change dose of enalapril 10mg po bid	White, RN, Carina	05/25 12:08	Secretary Completed
SHIN, HENRY	05/25/2011 11:28	OK to DC home from cardiac standpoint. F/U with Dr. Erickson in 1 week, coumadin clinic in 1 week.	White, RN, Carina	05/25 12:08	Secretary Completed
SHIN, HENRY	05/25/2011 11:28	1.2liter/day fluid restriction at home	White, RN, Carina	05/25 12:08	Secretary Completed
SHIN, HENRY	05/25/2011 11:33	Kdur 40MEq po x 1 now then 20mEq po daily	White, RN, Carina	05/25 12:08	Secretary Completed
SHIN, HENRY	05/25/2011 11:34	chem 6 in 1 week	White, RN, Carina	05/25 12:08	Secretary Completed
SHIN, HENRY	05/25/2011 11:34	D/C dobutamine	White, RN, Carina	05/25 12:08	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/25/2011 12:13	d/c foley Phone order written/repeated/verified per FOCHESATTOFILLHO, LUCIANO	White, RN, Carina	05/25 12:13	Secretary Completed
VENTURA, SALVATORE C	05/25/2011 18:30	foley CATH for 24 hour urine collection Phone order written/repeated/verified per VENTURA, SALVATORE C	White, RN, Carina	05/25 18:30	Secretary Completed
VENTURA, SALVATORE C	05/26/2011 6:29	Remove patient name from Dr. Ventura's list.	White, RN, Carina	05/26 8:18	Secretary Completed
Milenkovic, Steven Robert	05/26/2011 9:15	Chem 6 and BNP in am.	White, RN, Carina	05/26 9:16	Secretary Completed
Milenkovic, Steven Robert	05/26/2011 9:15	D/C IV Lasix after pm dose and restart 80mg po BID in am of 5/27.	White, RN, Carina	05/26 9:16	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/26/2011 9:26	Discharge Home	White, RN, Carina	05/26 10:43	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/26/2011 9:33	pt's bp > 100 of systolic	White, RN, Carina	05/26 10:43	Secretary Completed
FOCHESATTOFILLHO, LUCIANO	05/26/2011 9:33	going home on low dose ACEI and BB	White, RN, Carina	05/26 10:43	Secretary Completed

Disposition

MD	MD Time	Admit to	RN	RN Time

Condition

Metro South Medical Center

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

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Vitals

Taken at	Taken by	Temp	Pulse	Resp	BP	Pulse Ox	Pain Scale	Wt (kg)	Wt. Chg.	Ht. (cm)	BMI	Head Circ. (cm)	EGA	USEGA	LMP	LMP Status	Comments
05/23 17:24	Burge, RN, Patricia	Oral 97.8	70	20	122/79	100%	Denies pain										pt on roomair
05/23 17:25	Burge, RN, Patricia	Oral 97.8	69	20	124/91	98%	Denies pain										pt on roomair
05/23 19:45	McCabe, RN, Janet	Oral 95.1	68	24	132/70		Denies pain										Vpacing Room Air
05/23 21:19	Shatteen, PCP, Angie E.						PCP entry										ACCU CHECK@210094
05/23 23:22	Shatteen, PCP, Angie E.	Oral 97.4	71	20	102/77	94%	PCP entry										
05/24 0:00	McCabe, RN, Janet						Denies pain										Vpacing Room Air
05/24 1:30	McCabe, RN, Janet		72	24	97/89		Denies pain										Paced Room A
05/24 6:01	Shatteen, PCP, Angie E.						PCP entry	85.9	0								accu check@050062
05/24 6:01	Shatteen, PCP, Angie E.						PCP entry										accu check@060068
05/24 9:42	Critchett, RN, Daisyrenee						0										accucheck 54 Notified Dr. Harris
05/24 9:57	Bayless, RN, Michel				110/83	95%	Denies pain										2L nasal cannu
05/24 11:00	Garza, PCP, I Ana	Ax 94.2	69	20	118/83		PCP entry										
05/24 11:20	Garza, PCP, I Ana						PCP entry										70acc
05/24 13:45	Bayless, RN, Michel		69		109/85		Denies pain										
05/24 14:00	Bayless, RN, Michel		69		134/91		Denies pain										
05/24 14:32	Critchett, RN, Daisyrenee		69		128/92												
05/24 14:36	Critchett, RN, Daisyrenee		73		124/89												
05/24 14:48	Bayless, RN, Michel						Denies pain										acc 107
05/24 14:51	Critchett, RN, Daisyrenee		71		137/97												
05/24 15:00	Garza, PCP, I Ana	Ax 94.5	69	20	121/89		PCP entry										
05/24 15:36	Critchett, RN, Daisyrenee		69		134/96												
05/24 16:08	Garza, PCP, I Ana						PCP entry										108 acc
05/24 16:21	Critchett, RN, Daisyrenee		69		131/93												
05/24 17:07	Critchett, RN, Daisyrenee		71		140/97												
05/24 17:38	Critchett, RN, Daisyrenee		70		110/79												
05/24 17:41	Bayless, RN, Michel	R 96.9					Denies pain										paced
05/24 17:52	Critchett, RN, Daisyrenee		71		123/88												

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

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05/24 18:07	Critchett, RN, Daisyrenee		69		118/90					
05/24 18:23	Critchett, RN, Daisyrenee		69		109/88					
05/24 18:37	Critchett, RN, Daisyrenee		71		126/93					
05/24 18:37	Bahena, RN, Cecilia		71		126/93					
05/24 18:52	Critchett, RN, Daisyrenee		72		129/87					
05/24 18:52	Bahena, RN, Cecilia		72		129/87					
05/24 19:35	Bahena, RN, Cecilia		76		103/68					
05/24 19:52	Bahena, RN, Cecilia		75		110/78					
05/24 20:14	Bahena, RN, Cecilia	Oral 97.6	76	20	103/68	Denies pain				paced
05/24 20:49	Wylie,, PCP, Elana					PCP entry				accu=64 rn notified
05/24 20:52	Bahena, RN, Cecilia		69		116/86					
05/24 21:59	Bahena, RN, Cecilia		72		107/78					
05/24 22:01	Bahena, RN, Cecilia					Denies pain				accucheck 68 after apple jui with 2 sugars and cheese crackers
05/24 22:51	Bahena, RN, Cecilia		69		132/94					
05/24 22:55	Bahena, RN, Cecilia		69		119/89					
05/24 22:59	Wylie,, PCP, Elana					PCP entry				repeat accu=1
05/24 23:31	Wylie,, PCP, Elana	Oral 97.5	69	18	119/89	PCP entry				unable to obta o2 rn notified
05/24 23:56	Bahena, RN, Cecilia		69		115/90					
05/25 0:51	Bahena, RN, Cecilia		69		134/90					
05/25 1:51	Bahena, RN, Cecilia		72		129/93					
05/25 2:51	Bahena, RN, Cecilia		69		142/89					
05/25 3:16	Bahena, RN, Cecilia					Denies pain				Accucheck 153
05/25 3:52	Bahena, RN, Cecilia		69		109/81					
05/25 4:52	Bahena, RN, Cecilia		69		112/91					
05/25 5:23	Wylie,, PCP, Elana					PCP entry	86.6	0.7		
05/25 5:52	Bahena, RN, Cecilia		72		139/91					
05/25 6:32	Wylie,, PCP, Elana					PCP entry				accu=117
05/25 6:52	Bahena, RN, Cecilia		69		119/84					
05/25 7:59	White, RN, Carina	Oral 97.4	69	16	119/74	Denies pain				pt in bed room air. Dobutamir infusing at 5mcg/kg

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

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05/25 10:32	White, RN, Carina		68	16	127/87	95%	Denies pain				dobutamine dı 12.8 mg hour.
05/25 11:08	Garza, PCP, I Ana		69	18	127/87	98%	PCP entry				115 acc
05/25 15:16	Garza, PCP, I Ana	R 95.5	70	18	111/79		PCP entry				
05/25 16:30	Garza, PCP, I Ana						PCP entry				291 acc
05/25 20:21	Bahena, RN, Cecilia	Oral 97.7	69	20	123/86		Denies pain				afib;ra
05/25 21:00	Fontillas, PCP, Arthur						PCP entry				Accu-check = 193
05/26 1:00	Fontillas, PCP, Arthur						PCP entry				Accu-check = 211
05/26 1:05	Fontillas, PCP, Arthur	Oral 97.8	69	22	130/90	99%	PCP entry	88.2	1.6		Room Air
05/26 5:00	Fontillas, PCP, Arthur						PCP entry				Accu-check = 153
05/26 8:35	White, RN, Carina	Oral 97.9	75	16	107/74	96%	Denies pain				pt is on rroom
05/26 11:40	Yang, PCP, Hai L	Oral 97.4	69	20	130/91	95%	PCP entry				accucheck 186

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Clinical-InterDisciplinary Notes

Date/Time	Note Type	Clinical Note	Staff
05/23/2011 16:42	ADMISSION	Nursing - Admission - CORE MEASURES ASSESSMENT (Rev 01/06/11): Have you had a flu shot this season (List date or answer no)-No--refuses Have you had the pneumonia vaccine (Pneumovax) in the past 10 years? (List date or answer no)-No--refuses Do you smoke?-Not anymore If reformed smoker, how long ago did you quit?-N/A Does anyone at home smoke?-No - Patient and family were directed to smoking cessation information anyway	Burge, RN, Patricia
05/23/2011 16:42	ADMISSION	Nursing - Admission - DVT/VTE PROPHYLAXIS SCREENING (Rev 1/7/10): Is the patient on maintenance anticoagulation (warfarin, heparin or fondaparinux)?-Yes - No further assessment needed at this point. Order baseline INR if takes Warafin and not already done The baseline INR =-No baseline INR done - order placed. See diagnostics, will monitor	Burge, RN, Patricia
05/23/2011 16:43	ADMISSION	Nursing - Admission - FALL RISK ADMISSION INTERVENTIONS: TOTAL SCORE from admission assessment- = 5 or more - STANDARD AND HIGH RISK INTERVENTIONS AS NOTED BELOW Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter.	Burge, RN, Patricia
05/23/2011 16:43	WOUNDS	Nursing - Admission - FIRST WOUND ASSESSMENT (rev 11/04/10): WOUND ASSESSMENT-No wounds at this time, no further assessment needed. TOTAL NUMBER OF WOUNDS NOTED UPON ADMISSION-N/A - no wounds present upon admission SECOND TIER WOUND ASSESSMENT CONDUCTED BY-Second RN Name -Michele EQUIPMENT-Pressure relief cushion WOUND ASSOCIATED PAIN-N/A WOUND TREATMENT-N/A	Burge, RN, Patricia

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

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05/23/2011 16:44 ADMISSION Nursing - Admission - RISK ASSESSMENT SCREENS: Burge, RN, Patricia

FUNCTIONAL SCREENING-Completed as follows
PT - Transferring-Requires assistance - person
PT - Ambulation-Completely independent
OT - Bathing-Requires assistance - person
OT - Dressing-Requires assistance - person
OT - Toileting-Requires assistance - person
OT - Feeding-Completely independent
SP - Communication-Effective
SP - Swallowing-Effective
SPIRITUAL/CULTURAL NEEDS-completed as follows
Religious beliefs-Baptist
Is your faith/spirituality an important part of your life?-No
Will being in the hospital interfere with any religious or cultural practices?-No
Do you have any specific requests to meet your spiritual/Cultural needs during hospitilization-No
PSYCHOSOCIAL NEEDS-assessed as follows
Are there any special difficulties produced by this hospitalization?-No
EDUCATIONAL NEEDS-assessed as follows
Current Illness-chf, htn
Treatment plan-meds
Medications-No needs
Pain management-No needs
Medical equipment-No needs
Nutrition/Diet-No needs
Rehabilitative techniques-No needs
Community resources-No needs
Personal hygiene/grooming-No needs
ASSETS/BARRIERS TO PLAN OF CARE-assessed as follows
Does patient have previous experience or knowledge related to reason for this hospitalization-Asset - Good knowledge base on diagnosis
Patient emotional/relational support system-Asset - Good support system in place with family/friends
Hearing-Asset - Normal hearing or corrected with hearing aides
Vision-Asset - Has normal vision or has corrected vision
Language-Asset - Speaks and understands English
Physical-Asset -Describe
Cognition/Mental status-Barrier - Describe -aox2
Cultural/Religious-No barrier
Does patients appearance demonstrate poor hygiene, malnutrition and/or dehydration-No
Does patient appear frightened or intimidated in the presence of caregiver?-No
Does the patient have unexplained bruises, lacerations, abrasions, burns, head injuries, sprains or fractures?-No

05/23/2011 16:47 ADMISSION Nursing - Admission - REFERRAL ASSESSMENT: Burge, RN, Patricia

Lives alone or with non-capable caregiver and needs post acute care-No
Currently uses home care devices-No
Lives in a nursing home or imtermediate care facility-No
New CVA diagnosis-No
New CABBG dignosis-No
Patient in foster care system-No
Active substance abuse confirmed by tox screen-No
Drug overdose/Attempted suicide-No
Unidentified patient-No
Undomiciled-No
New joint replacement/Amputee/Fracture-No
New HIV diagnosis-No
HX mental retardation-No
Suspected abuse/neglect-No
New Head/Spinal cord injury-No
Single parent under age 17 or adoption request-No
Pregnancy - High risk/Complicated pregnancy-No
Domestic abuse suspected or confirmed-No
New ostomy-No
PEG tube insertion-No
Terminal illness-No
New dialysis patient-No

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

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05/23/2011 16:49 ADMISSION — Nursing - Admission - PATIENT ASSESSMENT (rev 11/04/10): — Burge, RN, Patricia

Patient arrived on unit via-Wheelchair
Admit Source-Direct Admission
Transmission precautions indicated upon admission-Standard precautions indicated and followed
ORIENTATION TO ROOM/UNIT-Patient/significant other oriented to room and unit including the intial plan of care, call light and bed/TV controls, Bathroom and emergency call light, phone and was provided with an admission packet.
BELONGINGS-were inventoried and documented on belongings form, patient/family signature obtained.
Previous Hospitalizations-MSMC
CHIEF COMPLAINT-chf
SUMMARY OF HISTORY OF PRESENT ILLNESS-chf, htn, dm
Summary of prior treatment for present illness-meds
PAIN ASSESSMENT-Patient denies pain now
Patient personal acceptable level of pain is?-N/A
Location of pain?-N/A
Type of discomfort?-N/A
Comfort measures provided include?-quiet environment, warm blankets and distraction
Does patient use any alternative therapies?-N/A
PHYSICAL ASSESSMENT-was completed as noted below;
Mental status-Awake but disoriented (describe) -
Skin-Pink, warm and dry - capillary refill is brisk
Oral Mucosa-Lips and tongue are moist
Neck-Trachea is midline, no JVD is noted
Lung sounds-Clear to ascultation bilaterally
Retractions-No retractions are noted
Nasal flaring-is not present
Stridor-No stridor is heard
Abdomen-is hard,distended and non tender
Bowel sounds-Quiet bowel sound are heard x 4 quadrants
Lower extremities bilaterally-2 + edema is noted
Pedal pulses-are strong bilaterally
Pupils-Equal and reactive
Hand grasps-Strong and equal bilaterally
Ability to Move - right arm-strong
Ability to Move - left arm-strong
Ability to Move - right leg-moderate
Ability to Move - left leg-moderate
Tubes/Drains/Ostomy/Trach-None of these devices are present
Venous access device-None present on admission

05/23/2011 19:03 SHIFT NARRATIVE — Nursing - Serial - SHIFT END NOTE (new 4/19/11): — Burge, RN, Patricia

Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future
Diagnostic test review-I have reviewed all pertinent diagnostic data as available and appropriate during my shift
Patient report given and patient care endorsed to-Janet RN

05/23/2011 19:45 NURSING — Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) Recvd pt awake, alert, oriented to place and person, questionable on time. Denies pain. Vpacing on monitor. — McCabe, RN, Janet

05/23/2011 19:45 ADLs — Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): — McCabe, RN, Janet

TURN FREQUENCY-Patient able to reposition self frequently in bed
ACTIVITY-Bedrest with BRP
FEEDING-Self
COUGH AND DEEP BREATHING EXERCISES-Done every 2 hours while awake
EQUIPMENT – VTE (Venous Thromboembolism) Prophylaxis-N/A
LIST VTE PROPHYLAXIS CONTRAINDICATION (if applicable)-N/A

05/23/2011 19:45 VASCULAR ACCESS — Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): — McCabe, RN, Janet

PIVL Site 1 Location-Left AC Fossa pivl
PIVL Site 1 dressing label-date/Time placed - 20g 5-23
PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling
Patient's central venous access device continues to be necessary due to-N/A

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Allergies: nka

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05/23/2011 19:45	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Paced Rhythm LOC-Awake, Alert and Oriented x 2 Affect-Calm Eye Opening-4 spontaneous Verbal Response-5 Alert and Oriented X 2 Motor Response-6 obeys commands Pupils-reacts Ability to Move - right arm-moderate Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-moderate Skin Color-Normal Skin Temperature-cool Skin Moisture-Dry Skin turgor-non-tenting Respirations-Unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-No retractions noted Abdomen-distended, firm, non tender Bowel Sounds-Active x 4 quadrants Pedal Edema Right-2 plus Moderate 1/2 inch Pedal Edema Left-2 plus Moderate 1/2 inch Pedal Pulses Right-1 plus = Barely palpable Pedal Pulses Left-1 plus = Barely palpable	McCabe, RN, Janet
05/23/2011 19:45	WOUNDS	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10): WOUND ASSESSMENT-No wounds at this time, no further assessment needed. TOTAL NUMBER OF WOUNDS-# wounds = 0 EQUIPMENT-Pressure relief mattress on bed WOUND ASSOCIATED PAIN-N/A WOUND TREATMENT-N/A	McCabe, RN, Janet
05/23/2011 19:45	VASCULAR ACCESS	Nursing - Focused - IV START NOTE (new 12/21/09): Peripherally Inserted Vascular Lock- was established as follows Site used for start-Left AC Fossa Device Type/Size-Other - 20g butterfly Lock attached, secured with tape, line flushed easily after insertion.-Bioocclusive dressing applied, site was labelled with device type/size, start time, date and initials. Patient tolerance-Patient tolerated procedure well.	McCabe, RN, Janet
05/23/2011 19:50	NURSING	Pt to CT scan with RN, monitor per w/c, also went to chest xray	McCabe, RN, Janet
05/23/2011 19:52	SPIRITUAL CARE	Spiritual Care - Assessment: Religious affiliation-Christian Interventions - Prayer/scripture-pt received pryer and encouragement; appreciated the visit	Carney, PhD, Phillita T.
05/23/2011 19:53	PLAN OF CARE	Spiritual Care - Interdisciplinary Plan of Care: INTERVENTION-Spiritual care assessment completed and emotional needs identified OUTCOME-Accepts spiritual interventions and counseling	Carney, PhD, Phillita T.
05/23/2011 20:15	NURSING	Returned from CT Scan per w/c, assisted back to bed.	McCabe, RN, Janet
05/23/2011 21:20	NURSING	Accucheck = 94, no coverage ordered.	McCabe, RN, Janet
05/23/2011 22:30	NURSING	Dr. Cusick called with consult, no new orders received.	McCabe, RN, Janet
05/24/2011 0:00	SKIN ASSESSMENT	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT: Sensory Perception-= 4 - No impairment Moisture-4 - Rarely Moist Activity-3 - Walks Occasionally Mobility-3 - Slightly Limited Nutrition- = 4 - Excellent Friction and Shear- = 3 - No apparent problem Total Score-= 19 or more - No interventions needed at present - continue to monitor	McCabe, RN, Janet

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Allergies: nka

Room 4SO:421-01

05/24/2011 0:00	FALL RISK	Nursing - Serial - SHIFT FALL RISK ASSESSMENT/INTERVENTIONS (rev 12/10/10): Currently/History of - Confusion/Disorientation/Impulsivity-Yes = 4 HX Depression with active symptoms at present-No = 0 Altered elimination (Frequency/Urgency/Incontinence/Diuretics)-Yes = 1 Currently/History of - Dizziness/Vertigo-Yes = 1 Male Gender-No = 0 Currently taking anticonvulsants (check MAR)-No = 0 Currently taking benzodiazepines (check MAR)-No = 0 Mobility assessment reveals (Get up and Go Test)-Patient needs to push up but successful in 1 attempt = 1 TOTAL SCORE- = 5 or more - STANDARD AND HIGH RISK INTERVENTIONS AS NOTED BELOW Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter. If high risk, additional interventions below High risk precautions initiated-Includes Appropriate signage posted in room, chart labels on, Fall risk ID band applied, red slippers provided, hourly rounding done, proactive bladder program established and exit alarms are in place and active.	McCabe, RN, Janet
05/24/2011 0:00	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-Patient able to reposition self frequently in bed ACTIVITY-Bedrest with BRP FEEDING-Self COUGH AND DEEP BREATHING EXERCISES-Done every 2 hours while awake EQUIPMENT – VTE (Venous Thromboembolism) Prophylaxis-N/A LIST VTE PROPHYLAXIS CONTRAINDICATION (if applicable)-N/A	McCabe, RN, Janet
05/24/2011 0:00	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-left upper arm pivl PIVL Site 1 dressing label-date/Time placed -2-23 20g PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-N/A	McCabe, RN, Janet
05/24/2011 0:00	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Paced Rhythm LOC-awake, alert oriented to person always, unsure of time and place intermittently Affect-Calm Eye Opening-4 spontaneous Verbal Response-see above Motor Response-6 obeys commands Pupils-reacts Ability to Move - right arm-moderate Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-moderate Skin Color-Normal Skin Temperature-warm Skin Moisture-Dry Skin turgor-non-tenting Respirations-Unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-No retractions noted Abdomen-distended firm non tender Bowel Sounds-Active x 4 quadrants Pedal Edema Right-2 plus Moderate 1/2 inch Pedal Edema Left-2 plus Moderate 1/2 inch Pedal Pulses Right-1 plus = Barely palpable Pedal Pulses Left-1 plus = Barely palpable	McCabe, RN, Janet
05/24/2011 0:10	NURSING	Medication Administration Record Reconciled and Verified	McCabe, RN, Janet
05/24/2011 1:30	NURSING	Found pt sitting on side of bed, states "I want to go to the bathroom" Skin cool, dry. Speech somewhat slurred. Hand grasps equal, moderate strength. Accucheck done = 71. B/p 97/89 hr 72. Pt denies pain. Pt placed on bedpan, pt did not appear strong enough to walk to bathroom. Bladder scan done, 409ml in bladder.	McCabe, RN, Janet
05/24/2011 1:40	NURSING	Pt able to drink about 1/3 glass OJ with a packet of sugar, unable to void on bedpan, removed.	McCabe, RN, Janet

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/24/2011 2:00	NURSING	Found pt standing at foot of bed on way to bathroom, assisted to bathroom with 2 RN's. Pt voided and had bm, flushed before rn could see results. Walked back to bed. Speech clearer now. Pt states she feels better, requesting and given graham crackers. Sitting up in bed watching tv.	McCabe, RN, Janet
05/24/2011 4:00	NURSING	No major changes from previous assessment, patient remains neurologically and hemodynamically stable	McCabe, RN, Janet
05/24/2011 5:05	NURSING	Accucheck = 62, pt took rest of oj with sugar and then another 120ml of orange juice. Speech not slurred now, pt warmer and dry. Drinking readily with the straw.	McCabe, RN, Janet
05/24/2011 5:48	NURSING	Accucheck rechecked = 68. Pt warm and dry, speech clear, initiating conversation. Denies pain. Watching tv.	McCabe, RN, Janet
05/24/2011 6:45	SHIFT NARRATIVE	Nursing - Serial - SHIFT END NOTE (new 4/19/11): Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future Diagnostic test review-I have reviewed all pertinent diagnostic data as available and appropriate during my shift Patient report given and patient care endorsed to-Daisy, RN	McCabe, RN, Janet
05/24/2011 8:00	SKIN ASSESSMENT	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT: Sensory Perception-= 3 - Slightly Limited Moisture-3 - Occasionally moist Activity-3 - Walks Occasionally Mobility-3 - Slightly Limited Nutrition-3 - Adequate Friction and Shear- = 3 - No apparent problem Total Score-= 19 or more - No interventions needed at present - continue to monitor	Bayless, RN, Michel
05/24/2011 8:00	FALL RISK	Nursing - Serial - SHIFT FALL RISK ASSESSMENT/INTERVENTIONS (rev 12/10/10): Currently/History of - Confusion/Disorientation/Impulsivisity-Yes = 4 HX Depression with active symptoms at present-No = 0 Altered elimination (Frequency/Urgency/Incontinence/Diuretics)-Yes = 1 Currently/History of - Dizziness/Vertigo-No = 0 Male Gender-No = 0 Currently taking anticonvulsants (check MAR)-No = 0 Currently taking benzodiazepines (check MAR)-No = 0 Mobility assessment reveals (Get up and Go Test)-Patient needs to push up but successful in 1 attempt = 1 TOTAL SCORE- = 5 or more - STANDARD AND HIGH RISK INTERVENTIONS AS NOTED BELOW Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter. If high risk, additional interventions below High risk precautions initiated-Includes Appropriate signage posted in room, chart labels on, Fall risk ID band applied, red slippers provided, hourly rounding done, proactive bladder program established and exit alarms are in place and active.	Bayless, RN, Michel
05/24/2011 8:00	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Left AC Fossa PIVL Site 1 dressing label-Date/Time placed - 20g 5/23 PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-N/A	Bayless, RN, Michel

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/24/2011 8:00	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10):	Bayless, RN, Michel

Transmission Precautions-Standard
O2 Type/Liter Flow-Room Air
Rhythm Strip Interpretation-Paced Rhythm
LOC-Awake but confused
Affect-Calm and cooperative
Eye Opening-4 spontaneous
Verbal Response-4 Confused or disoriented
Motor Response-6 obeys commands
Pupils-equal and reactive
Ability to Move - right arm-moderate
Ability to Move - right leg-moderate
Ability to Move - left leg-moderate
Ability to Move - left arm-moderate
Skin Color-Normal
Skin Temperature-cool
Skin Moisture-Moist
Skin turgor-non-tenting
Respirations-Even and unlabored
Breath Sounds Right-Diminished
Breath Sounds Left-Diminished
Retractions-No retractions noted
Abdomen-Round, firm
Bowel Sounds-Active x 4 quadrants
Pedal Edema Right-2 plus Moderate 1/2 inch
Pedal Edema Left-2 plus Moderate 1/2 inch
Pedal Pulses Right-1 plus = Barely palpable
Pedal Pulses Left-1 plus = Barely palpable

05/24/2011 8:00	WOUNDS	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10):	Bayless, RN, Michel

WOUND ASSESSMENT-No wounds at this time, no further assessment needed.
TOTAL NUMBER OF WOUNDS-N/A - no wounds present upon assessment
EQUIPMENT-Pressure relief mattress on bed
WOUND ASSOCIATED PAIN-N/A
WOUND TREATMENT-N/A

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
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Allergies: nka **Room** 4SO:421-01

05/24/2011 8:38 OCCUPATIONAL THERAPY — Occupational Therapy - Inpatient Evaluation: — Barder, OT, Jennifer

Compensatory strategies for safety practiced in ADL/activity --Yes
Reason for referral-Weakness
PRIOR LEVEL OF FUNCTION-Independent ADL's prior to admission, pt lives with husband
Precautions-cardiac, safety
Subjective-"I feel unsteady."
OBJECTIVE ADL Feeding-Modified independent
Toileting-Standby assist
UE Dressing-Standby assist
LE Dressing-Standby assist
UE Bathing-Standby assist
LE Bathing-Standby assist
Grooming-Standby assist
Functional Communication-Able to communicate needs
Splinting/Adapted Equipment-Per pt, she was not using a device PTA. Recommend a tub transfer bench with back rest for home use.
Assessment-This 62 y/o female presents with general weakness, decreased ADL skills, decreased BUE strength, decreased balance with transfers, and mild decrease in endurance. Pt was cooperative during initial eval and would benefit from OT to improve overall strength and ADL skills.
Goals-1. Pt will practice gentle AROM exs for ADL needs. 2. Pt will demonstrate clothing retrieval from closet. 3. Pt will demonstrate energy conservation techniques for daily living.
Potential for reaching These Goals-Excellent
DISCHARGE RECOMMENDATIONS-Home with HHC OT
Treatment Plan-ADL's, ROM, Strengthening
Treatment Plan discussed with-Patient
Treatment frequency-3-5 times weekly
UE PROM-WFL
UE AROM-3/4 ROM at Bilateral shldrs, otherwise WFL
Hand function-Functional for feeding
LUE strength-3+/5
RUE strength-3+/5
Muscle Tone-Hypertonic
Sensation-Functional for ADL's
PAIN present level-Denies pain
Left UE Fine Motor Coordination-Opposes all digits
Right UE Fine Motor Coordination-Opposes all digits
Balance sitting - static-Good
Balance sitting - dynamic-fair
Balance standing - static-Fair
Balance standing - dynamic-Standby assist/ minimal assist
Sitting tolerance-Greater than 60 minutes
Standing tolerance-Approximately 1 minute with unilateral hold
Endurance-Fair for function
COGNITION-Oriented X 3
STM-Intact
LTM-Intact
Problem solving-fair
Judgement/Safety-fair
PERCEPTION Visual tracking-Intact
Neglect-none
Body image/scheme-intact
Spatial relationships-Reads clock
R/L discrimination-intact
BED MOBILITY/TRANSFERS Rolling-Standby assist
Supine<>Sit-Standby assist
Toilet transfer-Standby assist/minimal assist
Sit<>Stand-Standby assist Time: 45 min

05/24/2011 8:46 PLAN OF CARE — Occupational Therapy - INTERDISCIPLINARY PATIENT/FAMILY EDUCATION PLAN OF CARE: — Barder, OT, Jennifer

Special Learning Needs-No special learning needs identified
Educational Need-Treatment/Plan
Readiness to Learn-Accepting/Attentive
Teaching Method-Activity Based
Response to Teaching-Acknowledges understanding
Patient/Family taught the following-Compensatory strategies

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Allergies: nka

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05/24/2011 8:46	PLAN OF CARE	Occupational Therapy - Interdisciplinary Plan of Care: INTERVENTIONS-Assess functional skills performance OUTCOMES-Maximize independence in daily living skills	Barder, OT, Jennifer
05/24/2011 9:45	EP LAB	Nursing - Focused - EP LAB DEVICE INTERROGATION (rev 5/13/11): CURRENT DEVICE FUNCTION-Normal ICD Function COMPANY-Medtronic DEVICE STORED EVENTS/NOTES-No stored events DATE OF IMPLANT-May 13, 2010 MODE-VVIR UPPER RATE-120 LOWER RATE-70 ICD CURRENT PARAMETERS VT-OFF ICD CURRENT PARAMETERS VF->200 BPM ICD CHARGE TIME (seconds)-9.1 SECS BATTERY CHARGE (volts)-3.13V UNDERLYING RHYTHM-Other -DEPENDANT ATRIAL SENSING AMPLITUDE (mv)-0.4mv VENTRICULAR SENSING AMPLITUDE (mv)-unable to obtain LV SENSING AMPLITUDE (mv)-na ATRIAL IMPEDENCE (ohms)-703 OHMS VENTRICULAR IMPEDENCE (ohms)-323 OHMS LV IMPEDENCE (ohms)-NA RV SHOCK IMPEDENCE (ohms)-42 OHMS SVC SHOCK IMPEDENCE (ohms)-58 OHMS ATRIAL THRESHOLD (volts)-unobtainable VENTRICULAR THRESHOLD (volts)-0.5V@ 0.40ms LV THRESHOLD (volts)-NA ATRIAL % PACED-0 VENTRICULAR % PACED-97.3 % LV % PACED-NA PROGRAMMING CHANGES-Program changes made -RA UNDERSENSING ADDITIONAL COMMENTS- INCREASED SENSITIVITY TO 0.15mv	Bartkus, RN, Carol A

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Allergies: nka

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05/24/2011 9:56	PHYSICAL THERAPY	Physical Therapy - Inpatient Evaluation:	Bohanek, MPT, Amy

Reason for Referral-Weakness, gait training and prevent deconditioning
PRECAUTIONS-High fall risk precautions
Prior Level of Function-Per pt, she was Ind with all mobility tasks and ADLs PTA without a device.
Social History from-Home with Husband (who also has medical issues).
Ambulation devices-None
Level of Orientation-A + O x 3; Responses delayed at times
Observation-+Telemetry, +IV
Stairs-Yes
SUBJECTIVE-Pt reported, "This water just got in my legs overnight." Stated she had SOB with activity.
Present Pain Level-0
Range of Motion-Limited B shoudlers and slightly in B LE due to edema; Otherwise, WFL.
Strength-Approx. 3/5 to 3+/5 grossly.
Sensation/Proprioception-She denied any numbness / tingling.
Coordination-Fair-/Fair
Balance Sitting - static-Good/Fair +
Balance Sitting - dynamic-Good/Fair +
Balance Standing - static-Fair
Balance Standing - dynamic-Fair -/Fair
Bed Mobility - Supine<>Sit-Not assessed as pt was already up in the bathroom Ind upon entry.
Transfers Sit<>Stand-CGA
Transfers Bed<>Chair-CGA
Gait Device Used-HHA
Assist Needed-CGA
Distance-25'
Gait Analysis-Unsteady (Although, pt refused to use an assistive device); Decreased cadence and step length.
Endurance-Fair -. Pt reported SOB with activity. Unable to get an accurate O2 sat as her hands were too cold.
Instructions provided on fall safety-Yes (Verbal)
ASSESSMENT-Pt required encouragement to participate in the PT Eval and responses were delayed at times. She presented with general deconditioning and impaired gait, but was reluctant to use an assistive device despite PT suggestion. She would benefit from continued skilled PT to improve general strength, endurance, and balance needed for more safe & Ind functioning.
Goals/Time Frame-(3-5 days) Improve bed mobility to Sup A.
Goals/Time Frame-(3-5 days) Improve transfers to Sup A.
Goals/Time Frame-(3-5 days) Increase ambulation to Sup A x 150' with or without device and O2 sats > 90% on RA.
Potential for Physical Therapy-Fair+
Discharge Recommendations-Home with possible Home PT. Pt may need an assistive device for home use.
Treatment goals and plan were discussed and developed with patient and/or family-Yes
INTERVENTIONS PLANNED - Bed Mobility->
Range of Motion Exercise->
Transfer Training->
Endurance Training->
Gait Training->
Balance Exercises->
Treatment Frequency-3-5 X per week
Total TX Time-38 - 52 minutes

05/24/2011 10:09	PLAN OF CARE	Physical Therapy - INTERDISCIPLINARY PATIENT/FAMILY EDUCATION PLAN OF CARE:	Bohanek, MPT, Amy

Special Learning Needs-No special learning needs identified
Educational Need-Rehabilitation Techniques
Readiness to Learn-Accepting/Attentive
Teaching Method-Explanation/Discussion
Response to Teaching-Follow up needed - plan
Patient/Family taught the following-Fall prevention tips, physical therapy plan of care and home exercise program

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Allergies: nka

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05/24/2011 10:10	PLAN OF CARE	Physical Therapy - Interdisciplinary Plan of Care: PHYSICAL THERAPY Assess transfers->\nAssess bed mobility->\nAssess gait->\nInstruct in home exercise program->\nOUTCOME - Increase exercise independence->\nIncrease independence of mobility->\nIncrease safety->	Bohanek, MPT, Amy
05/24/2011 11:49	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard\nO2 Type/Liter Flow-Nasal Cannula-2L\nRhythm Strip Interpretation-Paced Rhythm\nLOC-Awake but confused\nAffect-Calm but uncooperative\nEye Opening-4 spontaneous\nVerbal Response-4 Confused or disoriented\nMotor Response-6 obeys commands\nPupils-equal and reactive\nAbility to Move - right arm-moderate\nAbility to Move - right leg-moderate\nAbility to Move - left leg-moderate\nAbility to Move - left arm-moderate\nSkin Color-Normal\nSkin Temperature-cool\nSkin Moisture-Moist\nSkin turgor-non-tenting\nRespirations-Even and unlabored\nBreath Sounds Right-Diminished\nBreath Sounds Left-Diminished\nRetractions-No retractions noted\nAbdomen-Soft and non-tender\nBowel Sounds-Active x 4 quadrants\nPedal Edema Right-2 plus Moderate 1/2 inch\nPedal Edema Left-2 plus Moderate 1/2 inch\nPedal Pulses Right-1 plus = Barely palpable\nPedal Pulses Left-1 plus = Barely palpable	Bayless, RN, Michel
05/24/2011 12:17	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10)- sent Dr Harris an Empower message regarding the D/C of the Colchicine	Bayless, RN, Michel
05/24/2011 13:55	CASE MANAGER	Case Management - INITIAL ASSESSMENT: Severity of illness =-chf on imaging\nIntensity of service =-dobutamine drip\nComments --meets inpt criteria.	Blazek, RN, Patricia Marie
05/24/2011 13:56	CASE MANAGER	CLINICALS FAXED TO WELLCARE. 877-844-8538. REF # 8876538. NOT EQ HEALTH SOLUTIONS CALL FOR ADMIT DX 786.05. Direct admit tele from pmd office with sob, wt gain and increase in abd girth. In office bg 23, improved to 47 after glucose tab. Also relates hx syncope 1 wk ago. Pmh: cardiomyopathy, dm, chf, htn, aicd. Bun 49, cr 1.8, gluc 44, ct brain neg for acute changes, cxr - bibasilar pleural effusions/congetive changes. 97.8-70-20-122/79-100%ra. Paced rhythm.Admit orders - standing orders, card consult, ac qid, lasix 80 iv bid. Per pmd - syncope, chf. Per card - chf, no acei or arb d/t cr. 5/24 bnp 2444, gluc 54, bun 51, cr 1.88. renal consult. Renal us pending. 94.2ax-69-20-118/83-95% 2l nc. Paced rhythm. Lasix iv bid, dobutamine drip. Dcp - home. f/u d/c needs as pt progresses.	Blazek, RN, Patricia Marie
05/24/2011 14:03	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10)- foley inserted. 100cc clear dark yellow urine out upon insertion. Ua and urcl sent to lab	Bayless, RN, Michel
05/24/2011 14:25	CHF RESOURCE NURSE	CHF CONSULT: CHF teaching done, brochure provided. Neice was present for teaching, states pt was admitted for edema, sob and altered mental status. Has been living with husband and using canned and processed foods. Heart failure overview discussed along with 2 gm sodium /64 oz fluid restrictive diet, medication, excersise, weight monitoring/recording,symptom recognition/ when to notify physician. Page 7 of carepath was provided. Sodium monitoring and recording was established as discharge goal. A follow up call will be made post discharge. Neice is a nurse and was very recptive to information discussed. Pt is verbally responsive but confused.	Hackett, RN, Ginny

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05/24/2011 17:25	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Paced Rhythm LOC-Drowsy Affect-Calm Eye Opening-4 spontaneous Verbal Response-5 Alert and Oriented X 3 Motor Response-6 obeys commands Ability to Move - right arm-strong Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-strong Skin Color-Normal Skin Temperature-cool Skin Moisture-Moist Skin turgor-non-tenting Respirations-Even and unlabored Breath Sounds Right-Diminished Breath Sounds Left-Diminished Retractions-No retractions noted Abdomen-Round, firm Bowel Sounds-Active x 4 quadrants Pedal Edema Right-2 plus Moderate 1/2 inch Pedal Edema Left-2 plus Moderate 1/2 inch Pedal Pulses Right-1 plus = Barely palpable Pedal Pulses Left-1 plus = Barely palpable	Bayless, RN, Michel
05/24/2011 19:18	SHIFT NARRATIVE	Nursing - Serial - SHIFT END NOTE (new 4/19/11): Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future Diagnostic test review-I have reviewed all pertinent diagnostic data as available and appropriate during my shift Patient report given and patient care endorsed to-CeCe RN	Bayless, RN, Michel
05/24/2011 20:00	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) patient received aler and orientedx3; Pt denies cp and sob; Pt is paced; See assessment area; d5.9ns with 20kcl @70cc/hr; Dobutamine @ 12.7/hr infusing without complications to lac iv site; +Blood return noted to LAC Iv site; Will monitor	Bahena, RN, Cecilia
05/24/2011 20:00	SKIN ASSESSMENT	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT: Sensory Perception-= 4 - No impairment Moisture-4 - Rarely Moist Activity-3 - Walks Occasionally Mobility-3 - Slightly Limited Nutrition-3 - Adequate Friction and Shear-3 - No Apparent Problem Total Score-= 19 or more - No interventions needed at present - continue to monitor	Bahena, RN, Cecilia
05/24/2011 20:00	FALL RISK	Nursing - Serial - SHIFT FALL RISK ASSESSMENT/INTERVENTIONS (rev 12/10/10): Currently/History of - Confusion/Disorientation/Impulsivisity-No = 0 HX Depression with active symptoms at present-No = 0 Altered elimination (Frequency/Urgency/Incontinence/Diuretics)-Yes = 1 Currently/History of - Dizziness/Vertigo-No = 0 Male Gender-No = 0 Currently taking anticonvulsants (check MAR)-No = 0 Currently taking benzodiazepines (check MAR)-No = 0 Mobility assessment reveals (Get up and Go Test)-Patient needs to push up but successful in 1 attempt = 1 TOTAL SCORE- = 4 or less - STANDARD FALL RISK INTERVENTIONS AS NOTED BELOW Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter. If high risk, additional interventions below High risk precautions initiated-N/A	Bahena, RN, Cecilia

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Allergies: nka

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05/24/2011 20:00	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-Patient able to reposition self frequently in bed ACTIVITY-Bedrest with BSC	Bahena, RN, Cecilia
05/24/2011 20:00	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Left AC Fossa PIVL Site 1 dressing label-Date/Time placed - lac 20 5/23 PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-N/A	Bahena, RN, Cecilia
05/24/2011 20:00	WOUNDS	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10): WOUND ASSESSMENT-No wounds at this time, no further assessment needed. TOTAL NUMBER OF WOUNDS-N/A - no wounds present upon assessment EQUIPMENT-Pressure relief mattress WOUND ASSOCIATED PAIN-N/A WOUND TREATMENT-N/A	Bahena, RN, Cecilia
05/24/2011 20:00	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Atrial Fib LOC-Awake, Alert and Oriented x 3 Affect-Calm and cooperative Eye Opening-4 spontaneous Verbal Response-5 Alert and Oriented X 3 Motor Response-6 obeys commands Pupils-equal and reactive Ability to Move - right arm-strong Ability to Move - right leg-strong Ability to Move - left leg-strong Ability to Move - left arm-strong Skin Color-Normal Skin Temperature-warm Skin Moisture-Dry Skin turgor-non-tenting Respirations-Even and unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-Intercostal Abdomen-Round;soft ascites Bowel Sounds-Active x 4 quadrants Pedal Edema Right-1 plus Mild 0-1/4 inch Pedal Edema Left-1 plus Mild 0-1/4 inch Pedal Pulses Right-1 plus = Barely palpable Pedal Pulses Left-1 plus = Barely palpable	Bahena, RN, Cecilia
05/24/2011 20:45	NURSING	blood sugar 64; Patient asymptomatic; Patient given apple juice with sugar and sandwich; Will monitor	Bahena, RN, Cecilia
05/24/2011 22:11	NURSING	Dr Amin notified of accucheck; Orders received and initiated	Bahena, RN, Cecilia
05/24/2011 23:00	NURSING	Accucheck 140	Bahena, RN, Cecilia
05/25/2011 0:00	NURSING	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10):Transmission Precautions-Standard,O2 Type/Liter Flow-Room Air,Rhythm Strip Interpretation-Atrial Fib,LOC-Awake, Alert and Oriented x 3,Affect-Calm and cooperative,Eye Opening-4 spontaneous,Verbal Response-5 Alert and Oriented X 3,Motor Response-6 obeys commands,Pupils-equal and reactive,Ability to Move - right arm-strong,Ability to Move - right leg-strong,Ability to Move - left leg-strong,Ability to Move - left arm-strong,Skin Color-Normal,Skin Temperature-warm,Skin Moisture-Dry,Skin turgor-non-tenting,Respirations-Even and unlabored,Breath Sounds Right-Clear,Breath Sounds Left-Clear,Retractions-Intercostal,Abdomen-Round;soft ascites,Bowel Sounds-Active x 4 quadrants,Pedal Edema Right-1 plus Mild 0-1/4 inch,Pedal Edema Left-1 plus Mild 0-1/4 inch,Pedal Pulses Right-1 plus = Barely palpable,Pedal Pulses Left-1 plus = Barely palpable	Bahena, RN, Cecilia
05/25/2011 3:16	NURSING	Accucheck 153	Bahena, RN, Cecilia
05/25/2011 3:20	NURSING	Iv noted leaking; left arm iv dc'd	Bahena, RN, Cecilia
05/25/2011 4:15	NURSING	After 5 unsuccessfuls attempt by Rey Rn; 22g placed to rfa by Stacey Rn from Er	Bahena, RN, Cecilia
05/25/2011 6:12	NURSING	Weight 85.4; dobutamine @5mcg/kg/min=12.8cc/hr	Bahena, RN, Cecilia
05/25/2011 7:30	NURSING	Medication Administration Record Reconciled and Verified	Bahena, RN, Cecilia

Metro South Medical Center

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25/2011 7:30	SHIFT NARRATIVE	Nursing - Serial - SHIFT END NOTE (new 4/19/11): Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future Diagnostic test review-I have reviewed all pertinent diagnostic data as available and appropriate during my shift Patient report given and patient care endorsed to-Carina Rn Additional shift end comments --Carina Rn aware to start 24 urine;stop iv fluids; give amp of d50; initiate new double concentration dobutamine; initiate new lasix dosage	Bahena, RN, Cecilia
05/25/2011 8:01	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) pt in bed, drowsy awaken with verbal stimuli, oriented x 2-3, forgetful. Pt has Dobuatime 5mcg/kg/min - 12.8 ml/hr infusing via pump into right forearm pvil, site patent and intact. Pt foley to gravity draining clear amber urine. Pt has trace edema, mild discoloration. Pt abd distended, bowel sound patent. Pt oriented to use call light, sr x 2 up bed locked and low position for safety. Cont to monitor.	White, RN, Carina
05/25/2011 8:05	SKIN ASSESSMENT	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT: Sensory Perception-= 4 - No impairment Moisture-4 - Rarely Moist Activity-1 - Bedfast Mobility-3 - Slightly Limited Nutrition-2 - Probably Inadequate Friction and Shear-3 - No Apparent Problem Total Score-= 15 - 18 - Mild risk - Initiated at risk interventions	White, RN, Carina
05/25/2011 8:06	PLAN OF CARE		White, RN, Carina
05/25/2011 8:27	PLAN OF CARE	Nursing - Serial - DAILY INTERDISCIPLINARY POC: Care Plan per Care Path Protocol->24 hour urine, dobutamine drip and monitor io KNOWLEDGE INT See Interdisciplinary Patient/Family Instruction Form-> DISCHARGE PLANNING INT->pending SKIN INT Monitor skin integrity->dry and intact PAIN INT Monitor pain using pain scale->denies at this time O2 therapy->room air Elevate HOB->30 degree Assess mobility->up as with assistance Assess transfers->assistance x 1-2 Assess gait->slightly unsteady need assistance x 1	White, RN, Carina
05/25/2011 8:32	FALL RISK	Nursing - Serial - SHIFT FALL RISK ASSESSMENT/INTERVENTIONS (rev 12/10/10): Currently/History of - Confusion/Disorientation/Impulsivisity-No = 0 HX Depression with active symptoms at present-No = 0 Altered elimination (Frequency/Urgency/Incontinence/Diuretics)-Yes = 1 Currently/History of - Dizziness/Vertigo-No = 0 Male Gender-No = 0 Currently taking anticonvulsants (check MAR)-No = 0 Currently taking benzodiazepines (check MAR)-No = 0 Mobility assessment reveals (Get up and Go Test)-Patient makes multiple attempts but is successful = 3 TOTAL SCORE- = 4 or less - STANDARD FALL RISK INTERVENTIONS AS NOTED BELOW Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter. If high risk, additional interventions below High risk precautions initiated-Includes Appropriate signage posted in room, chart labels on, Fall risk ID band applied, red slippers provided, hourly rounding done, proactive bladder program established and exit alarms are in place and active.	White, RN, Carina
05/25/2011 8:33	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Right Forearm PIVL Site 1 dressing label-Date/Time placed -5/23 PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-Multiple IV drug and/or fluid therapy requiring central venous access	White, RN, Carina

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

05/25/2011 8:33	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-At this time repositioned to left side, padding placed between bony prominences ORAL CARE-Assist PERI CARE-Assist FOLEY CARE-Complete SKIN CARE-Assist with skin cleaning and moisturizing ACTIVITY-Up in chair FEEDING-Set-up and assist COUGH AND DEEP BREATHING EXERCISES-Done every 2 hours while awake EQUIPMENT - Incentive spirometry-Done every one hour while awake EQUIPMENT – VTE (Venous Thromboembolism) Prophylaxis-SCD's in place and functioning LIST VTE PROPHYLAXIS CONTRAINDICATION (if applicable)-N/A TRACH CARE-none SITZ BATH-N/A	White, RN, Carina
05/25/2011 8:49	CASE MANAGER	Case Management - PROGRESS NOTE: Intensity of service-dobutamine drip Discharge plan --home. Comments --chf, syncope. 97.4-69-16-119/74. atr fib. Dobutamine drip, lasix increased to 100 mg iv q 8, d50 iv x 2 for ac 64-153. 24 u/a cr clearance pending.	Blazek, RN, Patricia Marie
05/25/2011 8:59	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Nasal Cannula Rhythm Strip Interpretation-Paced Rhythm LOC-Drowsy Affect-Calm and cooperative Eye Opening-3 to voice Verbal Response-4 Confused or disoriented Motor Response-4 flexion withdrawal Pupil right-2mm Pupil left-2mm Pupils-equal and reactive Ability to Move - right arm-moderate Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-moderate Skin Color-Normal Skin Temperature-warm Skin Moisture-Dry Skin turgor-tenting Respirations-Unlabored Breath Sounds Right-Diminished Breath Sounds Left-Diminished Retractions-No retractions noted Abdomen-Distended Bowel Sounds-Active x 4 quadrants Pedal Edema Right-1 plus Mild 0-1/4 inch Pedal Edema Left-1 plus Mild 0-1/4 inch Pedal Pulses Right-2 plus = Palpable Disappears with Pressure Pedal Pulses Left-2 plus = Palpable Disappears with Pressure	White, RN, Carina
05/25/2011 9:01	WOUNDS	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10): WOUND ASSESSMENT-No wounds at this time, no further assessment needed. TOTAL NUMBER OF WOUNDS-N/A - no wounds present upon assessment EQUIPMENT-Pressure relief mattress WOUND ASSOCIATED PAIN-Patient has pain - see clinical notes and/or vitals table for pain assessment WOUND TREATMENT-N/A	White, RN, Carina
05/25/2011 9:02	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) 24 hour urine for protein and creat, foley on ice.	White, RN, Carina
05/25/2011 9:06	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) pt up in the chair, warm fingertips, pulse ox placed on middle finger right hand.	White, RN, Carina

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25/2011 9:50	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-Patient able to reposition self frequently in bed ORAL CARE-Self SKIN CARE-Self ACTIVITY-Up in chair-brp FEEDING-Self	Garza, PCP, l Ana
05/25/2011 9:52	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10)pt pulse ox is 97-98 after 15 minutes of monitor continously.	White, RN, Carina
05/25/2011 9:57	PHYSICAL THERAPY	S: Pt was resting in supine upon entry. Stated she felt "better" today. O: Pt was able to perform bed mobility tasks with SBA using the rail. She stood with CGA and ambulated x 15' no device with CGA. She then requested to use the bathroom and was assisted there with CGA. Left pt on the toilet as she needed to have a BM. RN aware. A: Pt had 2 LOB during short distance ambulation today, but continues to refuse PT suggestion regarding the use of an assistive device to improve dynamic balance and safety. She is a high fall risk and would benefit from continued skilled PT to achieve more safe & Ind functioning. P: Continue POC. Treatment time: 10 minutes func ther ex.	Bohanek, MPT, Amy
05/25/2011 10:00	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) Dr Shin in to see pt discontinue Dobutamine Drip and pt pull foley, no tramua noted to vagina area , order to discontinue foley, pt intructed to use bathroon and void in hat provided.	White, RN, Carina
05/25/2011 10:54	NUTRITION	NUTRITION: CHF Diet Instruction completed. Pt up in chair on RD visit. CHF Resource DI noted and reinforced to pt. RD reviewed 2gm Na diet, 64ounce Fluid Restriction and Wt Monitoring. Educational materials including Sample Menu and RD phone number provided. Advised pt to have husband or daughter, who shops and preps meals to review and contact RD w/any questions or concerns. Currently pt tolerating Diabetic diet w/good appetite/intake. RD to follow up low risk per protocol.	Burke, RD, LDN, Paula
05/25/2011 11:09	PHARMACY	Pharmacy - Coumadin Dosing Note New Dose: Coumadin consult was received on a-Female 62 years old INR-3.19 Hgb/Hct-14.7/44.8 Platelets-182 Coumadin Dose-No coumadin today. We will continue to follow and adjust therapy as needed for an INR goal of-2-3	Kannankeril, Jaya J.
05/25/2011 12:34	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) Pt aunt (Inez and Loretta) into see pt, called to stated she will need a ride home, pt has no order from primary for discharge, on cardiologist. Pt w ill probably be discharge tommorw. Spoke with her aunts, pt is forgetful at time, almost pull out foley. Spoke with Dr lucanio keep to until tommorrow, monito in place. Calll liight near, pt encouraged to use calll light if needing assistance. Pt bed lock and low postion for safety, cont to monil	White, RN, Carina
05/25/2011 16:30	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Right Forearm PIVL Site 1 dressing label-Date/Time placed -5/23 PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-Multiple IV drug and/or fluid therapy requiring central venous access	White, RN, Carina

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25/2011 16:30	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Normal Sinus Rhythm LOC-Awake, Alert and Oriented x 3 Affect-Calm Eye Opening-3 to voice Verbal Response-5 Alert and Oriented X 3 Motor Response-6 obeys commands Pupil right-2mm Pupil left-2mm Pupils-equal and reactive Ability to Move - right arm-moderate Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-moderate Skin Color-Normal Skin Temperature-cool Skin Moisture-Dry Skin turgor-non-tenting Respirations-Unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-No retractions noted Abdomen-Distended Bowel Sounds-Active x 4 quadrants Pedal Edema Right-1 plus Mild 0-1/4 inch Pedal Edema Left-1 plus Mild 0-1/4 inch Pedal Pulses Right-2 plus = Palpable Disappears with Pressure Pedal Pulses Left-2 plus = Palpable Disappears with Pressure	White, RN, Carina
05/25/2011 16:32	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) restart 24 hour urine agiain, pt forgetting to urinate in the hat., explain needed for test of the kidney for tom. Ana pcp aware pt need protein and creat clearance 24 hour restart again. Cont to monior.	White, RN, Carina
05/25/2011 18:31	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) please monitor pt 24 hour collection,keep foley intact to help collect uinre. Pt forget to save urine otherwise, per Dr Venture.	White, RN, Carina
05/25/2011 18:32	SHIFT NARRATIVE	Nursing - Serial - SHIFT END NOTE (new 4/19/11): Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future Additional shift end comments --pt in bed alert and oriented, forgetful at time, to save urine, although hat bathroon for her collected 24 hour urine. Pt dobutamne discontinue pvil in left arm pvil in place. Pt pain free. And new foley to help collect urine.	White, RN, Carina
05/25/2011 19:45	NURSING	Rn to bedside; No foley noted ; Patient refusing foley insertion; Patient explained importance of foley and md recommending foley; Patient continues to refuses and states it hurts	Bahena, RN, Cecilia
05/25/2011 19:51	NURSING	Dr Ventura notified of patient refusing foley and informed Rn if possible to place foley and attempt to collect 24 hour urine with or without foley; Rn informed if 24 hour urine unable to be collected secondary to patient's confusion; Dr Ventura stated will address with patient and primary md in am	Bahena, RN, Cecilia
05/25/2011 20:00	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) Patient received alert and oriented x3; Pt denies cp and sob; Pt is sr; See assessment area; Refer to carenotes for assessment; patient reinstructed on saving urine	Bahena, RN, Cecilia
05/25/2011 20:00	NURSING	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT:Sensory Perception-= 4 - No impairment,Moisture-4 - Rarely Moist,Activity-3 - Walks Occasionally,Mobility-3 - Slightly Limited,Nutrition-3 - Adequate,Friction and Shear-3 - No Apparent Problem,Total Score-= 19 or more - No interventions needed at present - continue to monitor	Bahena, RN, Cecilia

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25/2011 20:00	NURSING	Nursing - Serial - SHIFT FALL RISK ASSESSMENT/INTERVENTIONS (rev 12/10/10):Currently/History of - Confusion/Disorientation/Impulsivity-No = 0,HX Depression with active symptoms at present-No = 0,Altered elimination (Frequency/Urgency/Incontinence/Diuretics)-Yes = 1,Currently/History of - Dizziness/Vertigo-No = 0,Male Gender-No = 0,Currently taking anticonvulsants (check MAR)-No = 0,Currently taking benzodiazepines (check MAR)-No = 0,Mobility assessment reveals (Get up and Go Test)-Patient needs to push up but successful in 1 attempt = 1,TOTAL SCORE- = 4 or less - STANDARD FALL RISK INTERVENTIONS AS NOTED BELOW,Standard precautions initiated-Includes initial and ongoing fall risk education, safe room set-up including call light in reach and not dangling, moving furniture on non-exit side of bed, side rails up x2, bed locked and low, adequate lighting and room is clear of clutter. If high risk, additional interventions below,High risk precautions initiated-N/A	Bahena, RN, Cecilia
05/25/2011 20:00	NURSING	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11):TURN FREQUENCY-Patient able to reposition self frequently in bed,ACTIVITY-Bedrest with BSC	Bahena, RN, Cecilia
05/25/2011 20:00	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Right Forearm PIVL Site 1 dressing label-Date/Time placed -5/25 22g PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-N/A	Bahena, RN, Cecilia
05/25/2011 20:00	NURSING	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10):WOUND ASSESSMENT-No wounds at this time, no further assessment needed.,TOTAL NUMBER OF WOUNDS-N/A - no wounds present upon assessment,EQUIPMENT-Pressure relief mattress,WOUND ASSOCIATED PAIN-N/A,WOUND TREATMENT-N/A	Bahena, RN, Cecilia
05/25/2011 20:00	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Atrial Fib LOC-Awake, Alert and Oriented x 3 and forgetful Affect-Calm and cooperative Eye Opening-4 spontaneous Verbal Response-5 Alert and Oriented X 3 Motor Response-6 obeys commands Pupils-equal and reactive Ability to Move - right arm-strong Ability to Move - right leg-strong Ability to Move - left leg-strong Ability to Move - left arm-strong Skin Color-Normal Skin Temperature-warm Skin Moisture-Dry Skin turgor-non-tenting Respirations-Even and unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-No retractions noted Abdomen-Soft and non-tender Bowel Sounds-Active x 4 quadrants Pedal Edema Right-1 plus Mild 0-1/4 inch Pedal Edema Left-1 plus Mild 0-1/4 inch Pedal Pulses Right-1 plus = Barely palpable Pedal Pulses Left-1 plus = Barely palpable	Bahena, RN, Cecilia
05/25/2011 21:00	NURSING	Due to patient's previous hypoglycemic events; will hold insulin coverage	Bahena, RN, Cecilia
05/26/2011 0:00	NURSING	Medication Administration Record Reconciled and Verified	Bahena, RN, Cecilia
05/26/2011 0:00	NURSING	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10):Transmission Precautions-Standard,O2 Type/Liter Flow-Room Air,Rhythm Strip Interpretation-Atrial Fib,LOC-Awake, Alert and Oriented x 3 and forgetful,Affect-Calm and cooperative,Eye Opening-4 spontaneous,Verbal Response-5 Alert and Oriented X 3,Motor Response-6 obeys commands,Pupils-equal and reactive,Ability to Move - right arm-strong,Ability to Move - right leg-strong,Ability to Move - left leg-strong,Ability to Move - left arm-strong,Skin Color-Normal,Skin Temperature-warm,Skin Moisture-Dry,Skin turgor-non-tenting,Respirations-Even and unlabored,Breath Sounds Right-Clear,Breath Sounds Left-Clear,Retractions-No retractions noted,Abdomen-Soft and non-tender,Bowel Sounds-Active x 4 quadrants,Pedal Edema Right-1 plus Mild 0-1/4 inch,Pedal Edema Left-1 plus Mild 0-1/4 inch,Pedal Pulses Right-1 plus = Barely palpable,Pedal Pulses Left-1 plus = Barely palpable	Bahena, RN, Cecilia
05/26/2011 1:00	NURSING	Due to patient's hypogylcemic events will hold coverage; will recheck blood sugar in am	Bahena, RN, Cecilia

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/26/2011 5:00	NURSING	blood sugar 153; will monitor	Bahena, RN, Cecilia
05/26/2011 5:53	NURSING	Patient noted incontinent of urine; 24 hour urine incomplete and terminated; Will inform Dr Ventura when he rounds	Bahena, RN, Cecilia
05/26/2011 6:14	NURSING	Dr Ventura aware of 24hour urine incomplete and terminated	Bahena, RN, Cecilia
05/26/2011 6:43	SHIFT NARRATIVE	Nursing - Serial - SHIFT END NOTE (new 4/19/11): Medical Orders review-I have reviewed and as appropriate carried out all medical orders during my shift, except those orders endorsed to the oncoming RN and/or are scheduled in the future Diagnostic test review-I have reviewed all pertinent diagnostic data as available and appropriate during my shift Patient report given and patient care endorsed to-Carina Rn	Bahena, RN, Cecilia
05/26/2011 6:45	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-Patient able to reposition self frequently in bed ORAL CARE-Self PERI CARE-Self FOLEY CARE-N/A SKIN CARE-Self ACTIVITY-Assist - BRP FEEDING-Self	Fontillas, PCP, Arthur
05/26/2011 8:18	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) I want to go today, pt stated. Pt refused foley and up in the chair. Alert and oriented x3. pt void per brp, pivil right arm patent and intact, flushes well. Pt denies any pain and in no distress. Pt understand about monitor her input and output when she return home on fluid restriction. Call light, tray table and phone near bedside	White, RN, Carina
05/26/2011 8:20	SKIN ASSESSMENT	Nursing - Serial - DAILY BRADEN SKIN ASSESSMENT: Sensory Perception-= 4 - No impairment Moisture-4 - Rarely Moist Activity-2 - Chairfast Mobility-4 - No Limitations Nutrition-3 - Adequate Friction and Shear-3 - No Apparent Problem Total Score-= 19 or more - No interventions needed at present - continue to monitor	White, RN, Carina
05/26/2011 8:21	PLAN OF CARE	Nursing - Serial - DAILY INTERDISC. PATIENT/FAMILY EDUCATION POC: Special Learning Needs-No special learning needs identified Educational Need-Medications Readiness to Learn-Accepting/Attentive Teaching Method-Explanation/Discussion Response to Teaching-Follow up needed - plan Patient/Family taught the following- discuss filuid restriction upon discharge, monitor kidneys and blood count for coumadin	White, RN, Carina
05/26/2011 8:24	PLAN OF CARE	Nursing - Serial - DAILY INTERDISCIPLINARY POC: Care Plan per Care Path Protocol->possible discharge in today KNOWLEDGE INT See Interdisciplinary Patient/Family Instruction Form->DISCHARGE PLANNING INT->pending for today SKIN INT Monitor skin integrity->dry and intact PAIN INT Monitor pain using pain scale->denies O2 therapy->roomair Elevate HOB->30degree Assess mobility->u p as lib chair Assess transfers-can transfer self Assess gait->steady	White, RN, Carina

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/26/2011 8:25	ADLs	Nursing - Serial - SHIFT HYGIENE/ADL (rev 05/05/11): TURN FREQUENCY-Patient able to reposition self frequently in bed ORAL CARE-Self PERI CARE-Self FOLEY CARE-N/A SKIN CARE-Assist with skin cleaning and moisturizing ACTIVITY-Bedrest FEEDING-Self COUGH AND DEEP BREATHING EXERCISES-N/A EQUIPMENT - Incentive spirometry-N/A EQUIPMENT – VTE (Venous Thromboembolism) Prophylaxis-N/A	Yang, PCP, Hai L
05/26/2011 8:27	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Right Forearm PIVL Site 1 dressing label-Date/Time placed - PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling	White, RN, Carina
05/26/2011 8:28	ASSESSMENT	Nursing - Serial - SHIFT NURSING ASSESSMENT (rev 11/04/10): Transmission Precautions-Standard O2 Type/Liter Flow-Room Air Rhythm Strip Interpretation-Atrial Fib LOC-Awake, Alert and Oriented x 3 Affect-Calm and cooperative Eye Opening-4 spontaneous Verbal Response-5 Alert and Oriented X 3 Motor Response-6 obeys commands Pupil right-2mm Pupil left-2mm Pupils-equal and reactive Ability to Move - right arm-moderate Ability to Move - right leg-moderate Ability to Move - left leg-moderate Ability to Move - left arm-moderate Skin Color-Normal Skin Temperature-cool Skin Moisture-Moist Skin turgor-non-tenting Respirations-Unlabored Breath Sounds Right-Clear Breath Sounds Left-Clear Retractions-No retractions noted Abdomen-Soft Bowel Sounds-Active x 4 quadrants Pedal Edema Right-No edema noted Pedal Edema Left-No edema noted Pedal Pulses Right-2 plus = Palpable Disappears with Pressure Pedal Pulses Left-2 plus = Palpable Disappears with Pressure	White, RN, Carina
05/26/2011 8:35	WOUNDS	Nursing - Serial - SHIFT WOUND ASSESSMENT (rev 05/06/10): WOUND ASSESSMENT-No wounds at this time, no further assessment needed. TOTAL NUMBER OF WOUNDS-N/A - no wounds present upon assessment EQUIPMENT-Pressure relief mattress WOUND ASSOCIATED PAIN-N/A WOUND TREATMENT-N/A	White, RN, Carina
05/26/2011 9:50	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) pt sister(loretta) at bed side will like POT paper sign today if chaplin available.	White, RN, Carina
05/26/2011 10:43	RESPIRATORY	Respiratory - Assessment/Plan of Care: Oxygen-nc on sb	Kennerson, RT, Carol
05/26/2011 11:02	PHYSICAL THERAPY	Attempted to see pt in the AM for therapy, although she adamantly refused as she is scheduled for d/c to home later today. Will monitor.	Bohanek, MPT, Amy

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/26/2011 11:30	VASCULAR ACCESS	Nursing - Serial - SHIFT MULTIPLE LINE ASSESSMENT (rev 12/21/09): PIVL Site 1 Location-Right Forearm PIVL Site 1 dressing label-Date/Time placed - PIVL Site 1 Inspection-Site is clean and dry without redness, drainage or swelling Patient's central venous access device continues to be necessary due to-N/A	White, RN, Carina
05/26/2011 11:30	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) pt resting in chair, sister(loretta) call for pickup discharge home per md's. Pt is stable, pain free and accucheck with normal liimits.	White, RN, Carina
05/26/2011 11:59	PHARMACY	Pharmacy - COUMADIN NOTE FOLLOW UP DOSING: The patient chart and current labs-have been reviewed INR level-3.30 Pharmacy plan-Hold Coumadin dose for today and repeat INR in AM We will continue to follow and adjust as needed for an INR goal of-2.5 - 3.5	Kane Rph, Richard
05/26/2011 12:33	SPIRITUAL CARE	At bedside with pt.Introduced myself to pt as Chaplain Chapman and explained the purpose of my visit. That a family member has called this chaplain and said she wanted Power of Attorney Health Care done for pt.Pt stating she already has a Power of Attorney Health Care.Pt states she does not need Power of Attorney Health Care.Pt states she does not want Power of Attorney Health Care.	Chapman, Leland N.
05/26/2011 15:22	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) pt telemonitor remvoed,. Pivl cover with 2x2 to stop bleeding. Pt explain about meds and discharge instruction regarding CHF, fluid restriction at home 1.2 ml.	White, RN, Carina
05/26/2011 15:24	NURSING	Nursing - Serial - SHIFT NARRATIVE NOTE (new 6/29/10) request wheelchair for discharge cf# 19641 response time 16 minutes.	White, RN, Carina
05/26/2011 15:43	DISCHARGE	Nursing - Focused - DISCHARGE NOTE (rev 12/10/10): Patient is aware of the plan of care to discharge-Patient was made aware of plan of care to discharge and verbalized understanding Vascular access device(s)-PIVL D/C'd with catheter intact, dressing applied to site, no bleeding. Indwelling drains-None Belongings including any home meds if applicable-Were gathered and packed by family - inventory verified and signature obtained General Discharge Instructions-Patient not able to receive instructions. After care instructions relayed to care provider who verbalized goo understanding, had no questions unanswered, agrees to comply. Special Discharge Instructions-CHF Discharge instructions - Patient was given instruction on diet, exercise, weight monitoring, activity level, follow up and what to do if symptoms worsen. Transportation arrangements-Patient going home with family Patient was discharged to-Home with family Patient left unit-Accompanied by transporter via wheelchair	White, RN, Carina

Notifications By MD

No Notification Documentation

Notifications By RN

MD Notified	Page Time	Num Pages	Response Time
Harris, Richard G, M.D.	05/24 9:45	1	
Ventura, Salvatore C, M.D.	05/24 10:02		

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Intake

Start Time	End Time	Staff	Medicine/Device Type	Dosage/ Rate	Route/ Site	Amt.	Residual	Comments
05/23 21:41		McCabe, RN, Janet	COLCHICINE	0.6 MG-	ORAL	5 ML		
05/23 21:41		McCabe, RN, Janet	CARVEDILOL	25 MG-	ORAL	5 ML		
05/23 21:41		McCabe, RN, Janet	GLIPIZIDE	10 MG-	HELD DOSE	0 ML		as ordered until seen by Dr. Ahmed
05/23 21:42		McCabe, RN, Janet	FUROSEMIDE	80 MG-	ORAL	5 ML		rescheduled due to tests
05/23 21:42		McCabe, RN, Janet	FAMOTIDINE	20 MG-	ORAL	5 ML		
05/23 21:42		McCabe, RN, Janet	METOCLOPRAMIDE HCL	10 MG-	ORAL	5 ML		
05/23 21:43		McCabe, RN, Janet	SIMVASTATIN	40 MG-	ORAL	5 ML		
05/24 9:40		Bayless, RN, Michel	FAMOTIDINE	20 MG-	ORAL	1 Tablet		Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 9:40		Bayless, RN, Michel	METOCLOPRAMIDE HCL	10 MG-	ORAL	1 Tablet		Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 9:40		Bayless, RN, Michel	COLCHICINE	0.6 MG-	ORAL	1 Tablet		Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 9:40		Bayless, RN, Michel	CARVEDILOL	25 MG-	ORAL	1 Tablet		Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 9:40		Bayless, RN, Michel	FUROSEMIDE	80 MG-	IV Push	8 ML		Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 10:00		Critchett, RN, Daisyrenee	POTASSIUM CHLORIDE / D5W/0.9% NACL	70 ml/hr	INTRAVENOUS	0 ML	1000	Vitals Time: 05/24 14:48, BP: NA/NA, Pulse: NA, Respiration: N
05/24 10:10		Bayless, RN, Michel	D5W/0.9% NACL	70ml/hr	IV	0 ML	500	Vitals Time: 05/24 09:57, BP: 110/83, Pulse: NA, Respiration: N
05/24 14:00		Bayless, RN, Michel	DOBUTAMINE 500MG/250 D5W	250 ML-	INTRAVENOUS	0 ML	250	
05/24 15:44		Bayless, RN, Michel	METOCLOPRAMIDE HCL	10 MG-	ORAL	1 Tablet		Vitals Time: 05/24 15:00, BP: 121/89, Pulse: 69, Respiration: 2

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/24 18:01	Bayless, RN, Michel	WARFARIN SODIUM	5 MG-	ORAL	1 Tablet	Vitals Time: 05/24 17:41, BP: NA/NA, Pulse: NA, Respiration: N
05/24 18:02	Bayless, RN, Michel	FUROSEMIDE	80 MG-	INTRAVENOUS	8 ML	Vitals Time: 05/24 17:41, BP: NA/NA, Pulse: NA, Respiration: N
05/24 18:17	Garza, PCP, l Ana	PO Fluids		PO Fluids	120 ML	no appetite
05/24 21:11	Bahena, RN, Cecilia	CARVEDILOL	25 MG-	HELD DOSE	0 ML	Vitals Time: 05/24 20:49, BP: NA/NA, Pulse: NA, Respiration: N
05/24 21:11	Bahena, RN, Cecilia	FAMOTIDINE	20 MG-	ORAL	0 ML	Vitals Time: 05/24 20:49, BP: NA/NA, Pulse: NA, Respiration: N
05/24 21:11	Bahena, RN, Cecilia	METOCLOPRAMIDE HCL	10 MG-	ORAL	0 ML	Vitals Time: 05/24 20:49, BP: NA/NA, Pulse: NA, Respiration: N
05/24 21:11	Bahena, RN, Cecilia	SIMVASTATIN	40 MG-	ORAL	0 ML	Vitals Time: 05/24 20:49, BP: NA/NA, Pulse: NA, Respiration: N
05/25 7:00	Bahena, RN, Cecilia	IV Fluids		IV	840 ML	12 hour night shift
05/25 7:00	Bahena, RN, Cecilia	DOBUTAMINE 500MG/250 D5W,250 ML, ,INTRAVENOUS,AS needed,,DOBUTAMINE 500MG/250ML D5W,KASON, THOMAS T		IV	152.5 ML	12 hour nights
05/25 9:25	White, RN, Carina	POTASSIUM CHLORIDE	20 MEQ-	ORAL	1 Tablet	Vitals Time: 05/25 16:30, BP: NA/NA, Pulse: NA, Respiration: N
05/25 9:27	White, RN, Carina	FUROSEMIDE	100 MG-	INTRAVENOUS	0 ML	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1
05/25 9:27	White, RN, Carina	FAMOTIDINE	20 MG-	ORAL	1 ML	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1
05/25 9:28	White, RN, Carina	METOCLOPRAMIDE HCL	10 MG-	ORAL	1 Tablet	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1
05/25 9:28	White, RN, Carina	CARVEDILOL	25 MG-	ORAL	1 Tablet	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25 9:28	White, RN, Carina	FUROSEMIDE	80 MG-	PO Fluids	0 ML	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1
05/25 9:28	White, RN, Carina	FUROSEMIDE	80 MG-	IV Push	0 ML	Vitals Time: 05/25 15:16, BP: 111/79, Pulse: 70, Respiration: 1
05/25 9:28	White, RN, Carina	FUROSEMIDE	80 MG-	IV Push	0 ML	Vitals Time: 05/25 16:30, BP: NA/NA, Pulse: NA, Respiration: N
05/25 9:29	White, RN, Carina	ASPIRIN	325 MG-	ORAL	1 Tablet	Vitals Time: 05/25 07:59, BP: 119/74, Pulse: 69, Respiration: 1
05/25 16:00	White, RN, Carina	POTASSIUM CHLORIDE	40 MEQ-	ORAL	2 Tablet	Vitals Time: 05/25 16:30, BP: NA/NA, Pulse: NA, Respiration: N
05/25 16:20	White, RN, Carina	METOCLOPRAMIDE HCL	10 MG-	ORAL	1 Tablet	Vitals Time: 05/25 15:16, BP: 111/79, Pulse: 70, Respiration: 1
05/25 16:28	White, RN, Carina	WARFARIN PHARMACY DOSING	1 -	HELD DOSE	0 ML	Vitals Time: 05/25 15:16, BP: 111/79, Pulse: 70, Respiration: 1 inr 3.19
05/25 17:00	White, RN, Carina	FUROSEMIDE	80 MG-	IV Push	0 ML	Vitals Time: 05/25 16:30, BP: NA/NA, Pulse: NA, Respiration: N
05/25 18:01	White, RN, Carina	FUROSEMIDE	80 MG-	IV Push	0 ML	Vitals Time: 05/25 16:30, BP: NA/NA, Pulse: NA, Respiration: N
05/25 18:45	White, RN, Carina	ENALAPRIL MALEATE	10 MG-	ORAL	1 Supp	Vitals Time: 05/25 15:16, BP: 111/79, Pulse: 70, Respiration: 1
05/25 21:00	Bahena, RN, Cecilia	CARVEDILOL	25 MG-	ORAL	0 ML	Vitals Time: 05/25 21:00, BP: NA/NA, Pulse: NA, Respiration: N
05/25 21:00	Bahena, RN, Cecilia	FAMOTIDINE	20 MG-	ORAL	0 ML	Vitals Time: 05/25 21:00, BP: NA/NA, Pulse: NA, Respiration: N
05/25 21:00	Bahena, RN, Cecilia	METOCLOPRAMIDE HCL	10 MG-	ORAL	0 ML	
05/25 21:00	Bahena, RN, Cecilia	SIMVASTATIN	40 MG-	ORAL	0 ML	

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka **Room** 4SO:421-01

05/26 1:03	Bahena, RN, Cecilia	FUROSEMIDE	100 MG-	INTRAVENOUS	10 ML	Vitals Time: 05/25 21:00, BP: NA/NA, Pulse: NA, Respiration: N
05/26 1:09	Bahena, RN, Cecilia	ENALAPRIL MALEATE	10 MG-	HELD DOSE	0 ML	error in documentatior was not given
05/26 8:24	Yang, PCP, Hai L	PO Fluids		PO Fluids	360 ML	breakfast 100%
05/26 9:17	White, RN, Carina	POTASSIUM CHLORIDE	20 MEQ-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 9:17	White, RN, Carina	ENALAPRIL MALEATE	10 MG-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 9:17	White, RN, Carina	FAMOTIDINE	20 MG-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 9:17	White, RN, Carina	METOCLOPRAMIDE HCL	10 MG-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 9:17	White, RN, Carina	CARVEDILOL	25 MG-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 9:17	White, RN, Carina	FUROSEMIDE	80 MG-	HELD DOSE	0 ML	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(start in am
05/26 9:18	White, RN, Carina	ASPIRIN	325 MG-	ORAL	1 Tablet	Vitals Time: 05/26 08:35, BP: 107/74, Pulse: 75, Respiration: 1(
05/26 11:50	White, RN, Carina	FUROSEMIDE	100 MG-	INTRAVENOUS	0 ML	Vitals Time: 05/26 11:40, BP: 130/91, Pulse: 69, Respiration: 2(
05/26 12:30	Yang, PCP, Hai L	PO Fluids		PO Fluids	360 ML	lunch 100%

Output

Date/Time	Staff	Output Type	Amount (ml)	Comments
05/24/2011 2:00	McCabe, RN, Janet	Urine Output	0	up to bathroom, voided and had stool, pt flushed before rn saw results
05/24/2011 6:02	Shatteen, PCP, Angie E.	Urine Output	0	brpx 3
05/24/2011 16:00	Garza, PCP, l Ana	Urine Output	200	foley
05/24/2011 18:01	Garza, PCP, l Ana	Urine Output	150	foley

Metro South Medical Center

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[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

05/25/2011 5:23	Wylie,, PCP, Elana	Urine Output	650	foley
05/25/2011 11:00	White, RN, Carina	Urine Output	240	d/c foley
05/25/2011 22:02	Fontillas, PCP, Arthur	Stool	0	soft brown
05/26/2011 0:30	Fontillas, PCP, Arthur	Urine Output	350	yellow urine commode
05/26/2011 3:00	Bahena, RN, Cecilia	Urine Output	300	yellow urine bsc
05/26/2011 5:00	Fontillas, PCP, Arthur	Urine Output	0	BRP, didn't save urine
05/26/2011 14:19	Yang, PCP, Hai L	Urine Output	0	brp

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Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

Medication Reconciliation

Med Recon Type	Med Type	Medication	Status
ADMISSION	HOME MEDS	Aspirin 325 mg Tab, Daily	CONTINUE
ADMISSION	HOME MEDS	Chlordiazepoxide 25 mg Cap, At Bedtime as needed	CONTINUE
ADMISSION	HOME MEDS	Colace 100 mg Cap, Twice Daily as needed	CONTINUE
ADMISSION	HOME MEDS	Colchicine 0.6 mg Tab, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	Coreg 25 mg Tab, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	Digoxin 0.25mg PO, Daily	CONTINUE
ADMISSION	HOME MEDS	Enalapril 20mg PO, 1 tablet, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	Glipizide 10 mg Tab, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	HUMALOG 6units After Meals Subcutaneous, 6 UNITS, Three times daily AFTER Meals	CONTINUE
ADMISSION	HOME MEDS	Insulin Detemir SubQ, 20 units, At Bedtime	CONTINUE
ADMISSION	HOME MEDS	Lasix 80 mg Tab, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	Pepcid 20 mg Tab, Twice A Day	CONTINUE
ADMISSION	HOME MEDS	Reglan 10 mg Tab, Three Times A Day	CONTINUE
ADMISSION	HOME MEDS	Simvastatin 40 mg Tab, Daily	CONTINUE
ADMISSION	HOME MEDS	Warfarin 5 mg Tab, Daily	CONTINUE
ADMISSION	HOME MEDS	Zithromax 250mg PO, Daily	CONTINUE
DISCHARGE	HOME MEDS	Aspirin 325 mg Tab, 1 tablet, Daily	CONTINUE
DISCHARGE	HOME MEDS	Colace 100 mg Cap, 1 tablet, Twice Daily as needed	CONTINUE
DISCHARGE	HOME MEDS	Coreg 25 mg Tab, 1 tablet, Twice A Day	CONTINUE
DISCHARGE	HOME MEDS	diagnostic test to be completed, , One Time	CONTINUE
DISCHARGE	HOME MEDS	DOCUSATE SODIUM, 100 MG, 2x a day as needed	CONTINUE
DISCHARGE	HOME MEDS	Enalapril Maleate Oral, 2.5 mg , Twice A Day	CONTINUE
DISCHARGE	HOME MEDS	FAMOTIDINE, 20 MG, 2 times a day 0900,2100	CONTINUE
DISCHARGE	HOME MEDS	HUMALOG 6units After Meals Subcutaneous, 6 UNITS, Three times daily AFTER Meals	CONTINUE
DISCHARGE	HOME MEDS	Insulin Detemir SubQ, 10 units, At Bedtime	CONTINUE
DISCHARGE	HOME MEDS	Lasix Oral, 100 mg, Twice A Day	CONTINUE
DISCHARGE	HOME MEDS	Potassium Chloride 20meq PO, 1 tablet, Daily	CONTINUE
DISCHARGE	HOME MEDS	Simvastatin 40 mg Tab, , Daily	CONTINUE
DISCHARGE	HOME MEDS	Warfarin 5 mg Tab, , Daily	CONTINUE
DISCHARGE	HOME MEDS	ZALEPLON, 10 MG, at bedtime as need 2100	CONTINUE
DISCHARGE	HOSPITAL MEDS	ASPIRIN,325 MG, ,ORAL,daily	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	CARVEDILOL,25 MG, ,ORAL,2 times a day ,	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	CHLORDIAZEPOXIDE HCL,25 MG, ,ORAL,at bedtime as need	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	DOCUSATE SODIUM,100 MG, ,ORAL,2x a day as needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	ENALAPRIL MALEATE,10 MG, ,ORAL,2 times a day ,	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	FAMOTIDINE,20 MG, ,ORAL,2 times a day ,	DISCONTINUE

Metro South Medical Center

12935 South Gregory Street Blue Island, IL 60406-2428 (708) 597-2000

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	[redacted]	[redacted]	Female	[redacted]	WELLCARE	85.7kg	175.26cm	[redacted]	[redacted]

Allergies: nka

Room 4SO:421-01

DISCHARGE	HOSPITAL MEDS	FUROSEMIDE,100 MG, ,INTRAVENOUS,every 8 hrs	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	METOCLOPRAMIDE HCL,10 MG, ,ORAL,3 times a day	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	POTASSIUM CHLORIDE,20 MEQ, ,ORAL,daily	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	SIMVASTATIN,40 MG, ,ORAL,at bedtime	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	WARFARIN PHARMACY DOSING,1 , ,ORAL,daily	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	ZALEPLON,10 MG, ,ORAL,at bedtime as need	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	ACETAMINOPHEN,650 MG, ,ORAL,every 6hr as needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	ALUM-MAG HYDROXIDE-SIMETHICONE,30 ML, ,ORAL,AS needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	ATROPINE SULFATE,1 MG, ,INTRAVENOUS,AS needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	MAGNESIUM HYDROXIDE 15%,10 ML, ,ORAL,AS needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	NITROGLYCERIN,0.4 MG, ,SUBLINGUAL,AS needed	DISCONTINUE
DISCHARGE	HOSPITAL MEDS	TRIMETHOBENZAMIDE HCL,200 MG, ,INTRAMUSCULAR,every 6hr as needed	DISCONTINUE

Empower Inpatient™ Summary Chart for Faxing

Patient Name	Date of Birth	Gender	ID Number	ID Number Type	Address	Phone
[redacted]	[redacted]	Male	[redacted]	Medical Record Number	[redacted] CHICAGO, IL 60643	[redacted]

Physician Name	Date of Visit
Guterman, Seth J.	10/29/2012 10:17:00

Problem List

MD Name	Type	ICD-9 Code	Patient Problem	Status	Date Diagnosed
Guterman,Seth J.		716.90	Arthritis	Active	10/29/2012
	DIAGNOSIS	719.46	Knee Pain	Active	10/29/2012

Medication List

Rx Norm Code	Product	Generic Name	Brand Name	Strength	Dose	Route	Frequency	Date Started	Status
256217	Medication	ibuprofen	ibuprofen	200mg	2 tablet(400 MG)	Oral	4 times per day		ACTIVE

Medication Allergy List

Type	Code	Medication / Agent	Reaction	Status	Date Recorded
Drug Allergy	0	Denies allergies		ACTIVE	10/29/2012

Diagnostic Test Results

Type	LOINC Code	Test Name	Normal Range	Result	Date Performed
RADIOLOGY	73562	XR KNEE AP/LATERAL W/OBLIQUE(S)			10/29/2012

Patient Name	Age	DOB	Gender	Race	Insurance	Admitting Weight	Admitting Height	Medical Record	Account
[redacted]	28 yrs	[redacted]	Male	[redacted]	BLUE CROSS - OUT	70.31kg	182.88cm	[redacted]	[redacted]

Allergies: Denies allergies

Room ED:FT22-

Discharge-Home Instructions

Discharge Diagnosis

Knee Pain

Arthritis

Discharge Activity

Discharge Diet

Discharge Instructions

Work note -

Discharge Prewritten Instructions

Knee - Wear and Tear Disorders

Follow Up Date/Time	Practitioner Name	Clinic Name	Address	City	State	Zip	Phone
	Khan, Humaira, M.D.	MetroSouth Health	12246 S. Pulaski	Alsip	IL	60803	708-385-5601

Comments

Prescriptions

Rx: **Ibuprofen 200 mg Tab, Patient Instructions: take 2 tablet(400 MG) by oral route 4 times per day, Pharmacy Instructions: as needed for pain** Refills **0** Qty **20**

Rx: **Work note - No prolong standing or walking for 1 week** Refills **0** Qty **0**

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